THE PHYSICALITY OF THE SELF

MAGGIE TURP

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CONTENTS

ABSTRACT

The submitted publications address aspects of 'The Physicality of the Self' from a psychoanalytic perspective and in so doing extend the remit of psychoanalytic thinking. Conscious and unconscious investment of personal meaning in physical exercise, body-oriented behaviour and physical dimensions of experience and communication is explored through presentation and discussion of clinical case examples and infant observation material. The embodied nature of our being is identified as an issue of key significance in psychoanalysis, where unconscious communication, much of which is non-verbal, is a central concern of both theory and practice.

Ways of conceptualising psychosomatic disturbance are discussed, whether the disturbance emerges in physical symptoms without apparent organic underlay or in disturbed body-oriented behaviour such as eating disorders and self-injury. With regard to clinical practice, the central significance of receptivity to unconscious communication and capacity for containment (Bion 1962) is reaffirmed. The therapist's 'use of body' as part of the 'use of self' is discussed with particular reference to somatic communication in the transference – countertransference matrix.

The primary context for the work is a contemporary object relations framework. The perspective on embodiment or 'indwelling' developed by D. W. Winnicott and the post-Kleinian concept of 'psychic skin' are of particular importance. The disciplines of philosophy, psychology, neuroscience and sociology constitute a secondary, broader, context and inform the discussion of changing perspectives on 'mind', 'body', 'health' and 'illness'.

A 'continuum' model of self-care and self-harm is developed. The acronym 'cashas' is introduced to refer to 'culturally accepted self-harming acts/activities', behaviours which occupy a border area between good enough self-care and clinically relevant self-harm. Drawing on clinical material and research involving practitioner discussion of clinical vignettes, arguments are advanced for the relevance and clinical usefulness of the 'continuum' model.

NUMBERED LIST OF SUBMITTED PUBLICATIONS

1. Turp, M. (1997) The role of physical exercise in emotional well-being. In *Psychodynamic Counselling*, 3.2: 165-177.

2. Turp, M. (1998) In sickness and in health? Psychoanalysis and psychosomatics. In *Psychodynamic Counselling*, 4.1: 3-16.

3. Turp, M. (1999a) Encountering self-harm in psychotherapy and counselling practice. In *British Journal of Psychotherapy*, 15.3: 306-321.

4. Turp, M. (1999b) Touch, enjoyment and health: in infancy. In *European Journal of Psychotherapy, Counselling and Health*, 2.1: 19-35.

5. Turp, M. (1999c) Working with body storylines. In *Psychodynamic Counselling*, 5.3: 301-317.

6. Turp, M. (2000a) Touch, enjoyment and health: in adult life. In *European Journal of Psychotherapy, Counselling and Health*, 3.1: 61-76.

7. Turp, M. (2000b) Handling and self-handling: an object relations perspective on leisure exercise. In *Psychodynamic Counselling*, 6.4: 469-488.

8. Turp, M. (2000c) A response to 'Three Bodies in psychotherapy' by John Rowan. In *European Journal of Psychotherapy, Counselling and Health*, 3.2: 209-212.

9. Turp, M. (2002) The many faces of self-harm. In *Psychodynamic Practice* 8.2: 197 – 212.

10. Turp, M. (2001) *Psychosomatic Health: the body and the word*, London: Palgrave (boxed item).

11. Turp, M. (2003) *Hidden Self-Harm: narratives from psychotherapy*, London: Jessica Kingsley Publishers (boxed item).

PART 1

1.1: INTRODUCTION

The Critical Appraisal discusses nine journal papers and two books submitted for the award of PhD by publication, all of which are the sole work of the candidate. It is divided into three parts. Part 1 precedes the journal papers and consists of this introduction and a description of the evolution of the work. Part 2 comprises the submitted journal papers. Two books are also included as boxed items. Part 3 discusses areas of theoretical and clinical innovation and the overall contribution of the submitted work to the discipline of psychoanalysis, making the case for the suitability of the work for the award of PhD. The submission is situated within a wider context and the methodology employed, coherence and impact of the work are discussed.

The primary voice in evidence is that of the author as psychoanalytic psychotherapist reflecting on events unfolding in the consulting room. A secondary voice is that of the author as observer engaged in the activity of psychoanalytic infant observation. The material described and discussed is presented as a body of evidence emerging from clinical and observational encounters.

Embodiment, as experienced from within by the individual, is identified as a cornerstone of emotional and symbolic functioning and informs the discussion of various aspects of 'The Physicality of the Self'. The history of mind-body dualism and contemporary challenges to the dualistic model are discussed as part of the elaboration of a holistic and psychoanalytic model of functioning. Winnicottian, Kleinian and post-Kleinian developments are highlighted and significant points of contact between Winnicottian and post-Kleinian strands of thinking identified. Attention is drawn, for example, to a shared emphasis on the visceral basis of human experience. According to Winnicott:

> The live body, with its limits, and with an inside and an outside is felt by the individual to form the core for the imaginative self (1949:244).

This statement resonates with the Kleinian emphasis on the centrality of body-based phantasy in early life (Klein 1936, Heimann 1950) and with the compelling picture of holistic bodymind functioning emerging from infant observation studies. Winnicott's concern with 'an inside and an outside' and the issue of 'indwelling' is employed in the submitted work alongside the concepts of 'psychic skin' and 'second skin' (Bick 1968), expanded in later post-Kleinian work to include 'porous skin' (Briggs 1997, 1998), 'sonorous skin' (Sorensen 2000) and 'narrative skin' (Turp 2003, 2004 forthcoming).

A second point of contact is identified in the phenomenological flavour of Winnicott's work and of the post-Kleinian development of psychoanalytic infant observation. This flavour is reflected in the submitted work in the inclusion of substantial amounts of observational and clinical material. While it is acknowledged (Turp 2003: 70) that such material is not literally 'live', having inevitably been subject to conscious and unconscious selection and narrative smoothing, its inclusion represents a genuine attempt to ensure that individual voices are not drowned out by abstract formulations.

The immediate emotional experience of undertaking infant observations on the one hand and practising as a psychoanalytic psychotherapist on the other is the starting point for associations and reflections, for the discussion and development of theoretical frameworks and, eventually, for the location of emerging understandings within a wider social and philosophical context. Countertransference experience, involving strong emotions, physical sensations and unexpected images, thoughts and fantasies of action, are frequently referred to in the case study material and reference is made to descriptions by other analysts of similar phenomena (Field 1989, Ogden 1997).

It is in the nature of such experiences that they arise suddenly and as if from nowhere. I acknowledge that it is not possible to 'bracket off' assumptions, in the manner suggested by Husserl (1960) in his formulation of the law of épochè (Turp 2003: 68). Even immediate and intensely emotional experiences are in part socially constructed and involve elements of interpretation, both conscious and unconscious. While recognising this, I continue to argue for the importance of holding on to the raw feeling of the experience, even as a desire to understand brings to mind familiar frames of reference. In this sense, the work reflects the influence of phenomenological and post-modern considerations concerning the status of 'truth', 'reality' and 'narrative' and aspects of this discussion are referred to (Turp 1998, 2001:8-9, 2003: 69-70).

Themes highlighted in the work include:

- The emotional and developmental significance for the infant of experiences of maternal handling, as an aspect of overall care and containment
- Leisure exercise as a form of 'self-handling' informed by experiences in early object relations
- Touch and symbolic equivalents of touch in adult life and the place of narration of 'body storylines' in psychoanalytic psychotherapy
- Psychoanalytic infant observation as a sensitising process for the observer and a source of understanding of the relationship between mental and physical aspects of functioning

- Unconscious somatic communication in psychoanalytic psychotherapy
- 'Hidden' and low-key self-harm and 'self-harm by omission', resulting from striking lapses in self-care
- Vicissitudes of ordinary self-care and the nature and function of culturally accepted self-harming acts/activities ('cashas')
- Self-harming behaviour as an expression and communication of psychosomatic disturbance and an attempt to relieve states of dissociation and/or extreme distress
- The provision of sequencing narratives, described as 'narrative skin', as an aspect of maternal containment and psychoanalytic practice

1.2: EVOLUTION OF THE WORK

We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time

T. S. Eliot, *Four Quartets,* 1944

This submission has evolved from a process characterised by circling moves and sideways associations, hence the Critical Appraisal represents an attempt to provide a linear account of work that has emerged from an essentially non-linear process. Eliot refers to experiences have been visited and revisited, circled and re-circled, considered, then reconsidered from a different vantage point, and eventually known 'for the first time'. He seems to allude to false starts and incomplete or incorrect understandings that are a part of the uneven and disorderly nature of lived experience, of psychoanalysis itself and, in this instance, of my experience of working towards a PhD submission.

In 1997, following the completion of an MA in Psychoanalytic Studies at the Tavistock Centre, I considered enrolling with the University of East London/Tavistock Centre to pursue doctoral studies, with the idea at that stage of undertaking a specific piece of PhD-oriented research. While investigating this possibility, I continued to practice and think about my clinical work, had two papers accepted for publication and took advantage of an opportunity that arose in a different context to conduct a second infant observation. A body of work began to develop organically out of clinical experience,

infant observation and my continuing engagement with psychoanalytic thinking, characterised by 'an active passion for the type of knowledge it brings' (Caper 1997).

In 1998, I came across papers by Michael Rustin (1997) and Sue Reid (1997). In her paper, Reid proposes that psychoanalytic infant observation has the same structured form as a psychoanalytic clinical encounter, the same clear rules of engagement and the same potential for the generation of new ideas. She suggests that it constitutes a second core methodology to stand alongside the clinical case study, described by Michael Rustin (1997) as 'the equivalent of "Pasteur's laboratory" in the field of psychotherapy research'. I realised that I was already using these two 'core methodologies', each of them recognised as appropriate to the psychoanalytic endeavour. In my publications, I was presenting original case study and infant observation material and, in reflecting on and discussing that material, I was generating new interpretations of existing knowledge. In addition, my work was thematically coherent, the coherence deriving from my sustained interest in physical dimensions of experience, self-expression and communication.

These realisations eventually translated in my mind into the possibility of a PhD by publication. By this time most of the publications included in the submission had been written, either entirely or in outline. Hence they came into being without what might be thought of as anticipatory hindsight, without a sense of a point in the future (the point at which I now find myself) where I would be making a case for their coherence, originality and contribution to learning. In undertaking this task, I find myself in the interesting and paradoxical position of an 'as if' third party, uncomfortably aware of the impossibility of objectivity in relation to my own body of work.

PART TWO

2.1: PRELIMINARY NOTES ON JOURNAL PAPERS AND BOOKS

The candidate is the sole author of the submitted publications listed on page 2. With the exception of Turp 1999a and Turp 2002, the submitted journal papers have a special relationship to the book 'Psychosomatic Health: the body and the word (Turp 2001), with much of the observational and clinical material and associated theoretical development included in the journal papers being re-presented and expanded upon in this first book.

Turp 1999a and Turp 2002 have a special relationship to the second book 'Hidden Self-Harm: narratives from psychotherapy (Turp 2003) and it is suggested that these two journal papers be read immediately prior to that book rather than in chronological order. Turp 2003 also contains a substantial quantity of previously unpublished material.

The journal papers, being intended exclusively for a psychoanalytic readership, assume a certain level of reader sophistication and this is reflected in the style of writing and the level of technicality and theoretical complexity. In the books I have aimed for a more accessible style, with a potential multidisciplinary audience in mind and, in the case of the second book, an audience of interested service users and lay helpers as well. There is an inherent tension between an adequate rendering of psychoanalytic theory, given the subtle and complex readings of events involved, and accessibility to readers outside the discipline of psychoanalysis. I have endeavoured to work creatively with the tension between these concerns.

In the submitted books, I have taken advantage of the space available to include more extensive observational extracts and detailed accounts of clinical work. In the books also, more space is devoted to the task of locating the material and the ideas that emerge from it within a wider philosophical, historical and social context.

1.

Turp, M. (1997)

The role of physical exercise in emotional well-being.

Psychodynamic Counselling, 3.2: 165-77.

PSYCHODYNAMIC COUNSELLING 3.2 MAY 1997

The role of physical exercise in emotional well-being

A psychodynamic perspective

MAGGIE TURP

ABSTRACT This paper seeks to bring a psychodynamic perspective to bear on some non-pathological meanings which exercise may carry for its participants. It is informed by two core ideas: first, that it is possible to identify positive embodiments of psychological phenomena (as well as the negative embodiments described in the better-known pathological forms of psychosomatic symptoms and illnesses); and, second, that such positive embodiments are likewise linked to early object relations and may be discussed and understood in similar terms. In sketching out an area of interest which has previously received little attention, the paper draws upon research from the field of psychology and upon clinical examples as well as upon relevant psychoanalytic literature.

KEYWORDS Exercise, emotional well-being, sport, handling, infant observation, psychosomatics

INTRODUCTION

In my experience of clinical and supervisory practice, it is not unusual for a client to mention enjoying a sport, swimming, working out to an aerobics video or joining a gym. Over time, I have felt it important to recognize that some significant aspect of the client's narrative

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may be illuminated by bringing a psychodynamic sensitivity to bear upon such references. What position do such activities occupy in the client's inner world? What meanings do they carry and what is their relationship to the client's self-concept? While maintaining due respect for the specificity of a particular person's story, we may also look to psychoanalytic theory to assist us in reflecting upon these questions. At present there is rather little literature available to assist us unless the person's relationship to exercise has a clear pathological character.

CULTURAL AND HISTORICAL CONSIDERATIONS

Physical exercise combines at various margins with sport (compare swimming for pleasure or exercise with swimming in a competitive event), with enjoyment of our environment (consider a long country walk), with a more spiritual quest (as in Hatha yoga), or with aesthetic expression (as in dance). Furthermore, we all engage in some physical exercise – though less than during our grandparents' era – in the course of ordinary day-to-day living. In this article, the term 'exercise' is used in a restricted sense, to describe physical exercise undertaken as a leisure activity in a non-competitive context.

Surveying the great civilizations of the past, we find that sport and athletics have had a key role to play. The Greeks are famous for the high esteem in which they held athleticism and Romans greatly valued balance between mind and body and recognized the dangers of disequilibrium. Over recent years there has been a resurgence of enthusiasm for physical activity and a multi-million pound industry has been built upon the desire of large numbers of people to spend some of their leisure time participating in fitness activities. This trend has all the marks of a major popular cultural phenomenon. Purpose-built gyms and health centres have flourished, specialized clothing and footwear have entered the mainstream and had a major impact on fashion and new magazines catering to enthusiasts are now to be found in newsagents everywhere. In so far as psychoanalysts have expressed interest in this phenomenon, their reactions have been overridingly negative. For example, in an article in 1995, de la Torre claims that exercise has 'virtually attained the status of contemporary secular religion' and that 'For many young adults – and some who are not so young – attendance at a health club, assiduous participation in aerobics, and a daily walk in the park demand quasi-religious belief and dedication as well as a fear of

transgression' (de la Torre 1995). Undoubtedly, we do inhabit a world where appearance is bound up with success and status, perhaps to an unprecedented degree. In addition, the government and the media regularly urge us to exercise more, warning of the well-documented health risks of a sedentary lifestyle. There is no doubt that narcissistic considerations, together with fear of early heart disease, cancer, or other illness, have a part to play in our motivation to exercise. But personal and clinical experience together with the research outlined below suggest that this may not be the whole story. Other important motivations seem also to be in play, for example some kind of innate push towards using the body which remains active into and through adult life, and some kind of attempt to connect back to early experience which can be illuminated in object relations terms.

PSYCHOLOGY RESEARCH

Other disciplines, notably psychology and physiology, have undertaken research into the implications of fitness activities for their participants and some of their findings suggest fruitful possibilities for psychoanalytic thinking. To cite just a few of hundreds of studies, Berger and Owen (1992) found that college students participating in swimming and yoga classes recorded lower scores on anger, confusion, tension, and depression measures than did control (lecture class only) students. Among men and women aged 55–86 years old, participation in sport and physical recreation were significantly associated with 'a general optimism in life orientation' (O'Brien and Conger 1991). Berger, Friedman and Eaton (1988), in an experiment which randomly assigned participants to 'jogging', 'relaxation response', 'group interaction', or 'control' groups, found that jogging performed best in helping subjects to reduce short-term stress. These and almost all similar studies show benefits accruing – in regard to health, mood states, stress levels, and self-esteem – following the taking up of some kind of physical exercise. Motivation of participants has also been extensively investigated (e.g. Weinberg *et al.* 1993). Improving one's own performance, health benefits, and enhancing physical appearance all rate highly in such studies, but the commonly cited motivating factors are 'enjoyment', 'having fun' and 'feeling better'.

To summarize, psychological research offers ample evidence of the benign effects of physical exercise on emotional states. The effects

could be seen as merely secondary to reported health improvements, or due primarily to narcissistic satisfaction based on changes in body appearance, but such views do not accord with the emergence of 'enjoyment' and 'having fun' as the primary motivators.

PSYCHOSOMATICS

The extensive and eloquent literature on psychosomatic illness is evidence of the many and varied ways in which the body acts as communicator of emotional reactions in the form of psychosomatic symptoms. In relation to such symptoms, Joyce McDougall writes:

> The meaning is of a presymbolic order that circumvents the use of words . . . The emotion is not recognised in a symbolic way (that is, within the code of language which would have allowed the affect-laden representations to be named, thought about and dealt with by the mind), but instead is immediately transmitted by the mind to the body, in a primitive non-verbal way such as flight–fight impulses, thus producing the physical disorganisation that we call a psychosomatic symptom.
>
> (McDougall 1989)

Within this large body of literature, the focus is almost exclusively upon the pathological (in cases where exercise is excessive and obsessive). However, it is the same interconnectedness of mind and body which underlies the current hypothesis that we may also 'embody' constructively.

A question arises as to why such a possibility has not been explored with similar thoroughness. It may be, as Charles Rycroft has written, that:

> Psychoanalysis began as a branch of medicine and its raw material still derives from people who are in trouble and seeking help; it has therefore more to say about illness than about health, and a tendency to describe human nature in a terminology derived from pathology.
>
> (Rycroft 1991)

One might also reflect that Freud's early patients with their paralysed limbs needed rather literally to get 'back on their feet', and that psychoanalysis had its first successes in relation to ameliorating the symptoms of conversion hysteria. Success in bringing meaning to paralysed limbs seems to have been paralleled by a difficulty in bringing meaning to the opposite – limbs in vigorous movement!

THE ROLE OF PHYSICAL EXERCISE

In the article cited above, de la Torre states that 'Exercise undoubtedly helps to promote and maintain health and could be easily overlooked as a manifestation of different kinds of psychopathology'. Because of the analytic emphasis on pathology, one might argue that there is an even greater danger that exercise may be overlooked as a manifestation of psychological resilience or recovery. De la Torre cites exercise as 'a prophylactic agent and therapeutic aid in many *physical* illnesses', but does not acknowledge any possible emotionally therapeutic aspects of exercise. The view he puts forward regarding the various dynamic meanings of exercise distinguishes three different categories: healthy-neurotic, compulsive, and addictive, and goes on to offer three case examples by way of illustration. Useful and interesting as his elaboration is, it describes one end only – the pathological end – of a possible continuum.

While psychology research provides evidence that taking exercise has a significant impact on a subject's emotional state, research into psychosomatic illnesses reveals the multitude of ways in which emotional states can find disguised expression via the body. Taken together, these two sources attest strongly to a complex interrelatedness of psyche and soma. We do implicitly recognize that physical discharge can help psychical discharge. Nobody doubts that weeping expresses emotion, yet tears themselves are 'of the body'. Pacing the floor or tapping fingers seem to help both to express and to contain anxiety, and it is possible that vigorous physical activity may at times figure as a benign alternative to expression via psychosomatic symptoms.

PSYCHOANALYSIS AND SPORT

Sport and non-sporting fitness activities are evidently related and both involve vigorous exercise. Evidence from psychology research that formal or informal goal-setting plays an important part in most people's exercise programmes (e.g. Weinberg *et al.* 1993) encourages the possibility of understanding something of the meanings carried by physical exercise via study of the more abundant literature regarding psychoanalysis and sport. Significant differences also need to be acknowledged, including the probable importance of the competitive aspects of sport, in relation to the expression of both aggressive and libidinal drives, and also to the additional opportunities for vicarious participation, via spectatorship.

Freud's early work included the hypothesis of a 'drive for mastery' (Freud 1924), and as early as 1926 Helen Deutsch addressed the topic of sport within a contemporary Freudian psychoanalytic framework. She described the case of an adult male patient suffering from impotence, anxiety states, feelings of inferiority, and depression, who found his only relief in 'eagerly engaging in every possible kind of sport' (Deutsch 1926). Work in analysis revealed an infantile neurosis, followed by a phobia of balls and round objects which had come to represent the genital organs and an associated dread of castration. Mastery was obtained by intense participation in sports and Deutsch interpreted this in terms of the concepts of empowerment of the ego, exhibitionistic satisfaction, and an increase in self-esteem. She suggested that participation in sport may convert neurotic anxieties into externally located 'real world' anxieties and thus provide an enhanced opportunity for managing them.

Later writing has also alluded to the relevance of ideas of channelling and sublimating libidinal and aggressive energies when thinking about sport. In relation to football, Dr Barry Richards writes of sublimating 'the murderous meaning of the foot', drawing our attention to expressions such as 'putting the boot in' and 'a kick in the teeth'. He describes football as a 'civilising influence in the psychological sense', and as involving 'libidinal expression in a civilised setting'. A related concept is that of 'sensual muscularity' cited by Dr Richards in relation to playing football, but presumably also applicable to climbing a steep hill, holding a yoga position for a little longer or sweating over a weights machine in the gym. 'This modification of aggressive energies is perhaps aided by our memories of how as babies we express vigour and obtain pleasure through kicking movements, as well as using our feet to struggle against a restraining parent' (Richards 1994).

Another aspect of sport which has received attention is its provision of a structured framework for an encounter with the 'reality principle' (Freud 1911). Linking this to work within object relations, Dr Richards cites Winnicott's description of the ways in which the 'ordinary devoted mother' (Winnicott 1958) structures her infant's experience in such a way that unwelcome aspects of external reality are encountered in small doses, in portions which can be managed without recourse to defensive illusions (Richards 1994). In vigorous physical exercise too, often in a structured and managed setting, we are called upon to relinquish the notions of omnipotence characteristic of infancy and to face our inevitable limitations.

INFANT OBSERVATION

Theory arising from and appertaining to infant observations is a particularly fruitful source of understanding of the meaning of physical exercise, partly because the infant, being literally 'without speech', is more obviously dependent upon physical self-expression than the adult and partly because the focus of infant observation is on normal development, rather than on pathology.

Melanie Klein put forward the concept of the paranoid schizoid position (Klein 1946) characteristic of early infancy and arising from the infant's psychological need for an unqualifiedly good object around which to organize itself. In this regard, Judy Shuttleworth writes:

> The infant must be able to deal with states of distress or discomfort in such a way that the memory of them does not interfere with the capacity to be alert and satisfied at other times . . . To survive, the infant needs . . . to make use of an inherent capacity of the human mind for splitting and projection to rid himself of bad experiences and their internal equivalents.

This 'inherent capacity' seems to vary between individuals.

> Some infants seem able to cry and kick out when distressed in a way which enables them to rid themselves of what is troubling them . . . Other babies seem to cry in a more constricted way as if their misery remains locked inside them, leaving them less free to accept their mother's attention.
>
> (Shuttleworth 1989)

In Klein's view, the paranoid schizoid position was returned to at times of stress, and it is widely acknowledged that *in extremis* we are often drawn towards physical discharge, which can lead to danger for oneself or another. In the film of Jane Austen's *Sense and Sensibility*, Colonel Brandon pleads movingly with Elinor, sister of his beloved Marianne, who seems to be at death's door: 'Give me a task, or I shall run wild!' Other film examples include scenes where a protagonist, having faced some major frustration or disappointment, is then shown competing fiercely at squash or tennis. In these examples there seems to be acknowledgement that exercise may provide a safe setting for 'kicking out', enabling us to safeguard love and creativity until we can again accept the mixedness of our experiences and re-approach the integration of the depressive position (Klein 1935).

In his many papers, Winnicott recognized that for the infant physical and emotional are inseparable. The 'good enough mother'

provides physical care ('handling') along with emotional responsiveness ('holding') whereby she offers herself as a 'container', managing both the physical and emotional aspects of the baby's experiences which are beyond his capacity to negotiate alone. Like Klein, he recognizes that such holding is essential to the infant's mental development, but he also specifically acknowledges the importance of physical care:

> A subsidiary task in infant development is that of psycho-somatic indwelling . . . Much of the physical part of infant care – holding, handling, bathing, feeding, and so on – is designed to facilitate the baby's achievement of a psyche-soma that lives and works in harmony with itself.
>
> (Winnicott 1967)

There is compelling evidence that an infant's whole way of inhabiting its body, its muscle tone and its physical liveliness, reflects the handling it has experienced. For example, writing about babies whose mothers have shown an aversion to close physical contact, Juliet Hopkins observes 'These babies have been found to be no less cuddly at birth than other babies are, but by a year they neither cuddle nor cling but are carried like a sack of potatoes' (Hopkins 1990). As with emotional holding, physical handling is sometimes inadequate or insulting, yet our culture with its relatively restricted opportunities for close physical contact provides few opportunities for reparative work in this area. When a person joins a gym and perhaps engages a trainer, who like a good mother will guide, encourage, and protect against over-exertion, he or she may well be taking up one of the few opportunities available to compensate for poor handling in infancy.

Bick (1968) writes of the infant's first psychological need as one of being held together physically and describes how this gives the baby a feeling of being all of a piece within its skin. Where the mother's holding is not available, Bick describes how the infant is left to focus itself on non-human aspects of the environment (for example, staring at a light or a moving curtain) or may endeavour to hold itself together by using its own sensations of muscular tension, thereby developing what she called a 'second skin'. While the two latter modes of being held together have serious negative developmental implications when relied upon to excess, in moderation they are helpful to the infant's sense of integration. Physical exercise mirrors in some ways the infant's development of a sense of containment within the skin and of muscularity. Exercise and sport

require skill, co-ordination and complex movement, not just a toughening of the skin but a refining of it. In most forms of exercise, as in infancy, there is a progression from gross and approximate movements to precise and well-timed ones.

These considerations offer additional ways in which we might understand an exerciser's enhanced sense of skin and muscularity to be psychologically helpful. In general, vigorous exercise may serve as a bodily reminder of a growing sense of agency and resourcefulness, a reminder which may mitigate an otherwise overwhelming sense of helplessness at a time of crisis. In addition, for a person who had and has insufficient containment, regular work-outs may serve to bolster his or her 'second skin' at some cost to emotional possibilities but also possibly warding off a very real danger of breakdown.

Brazelton has described and captured on video the extraordinary range and nuance of movement, gesture, facial expression, and vocalization whereby the baby indicates its changing experiences to the mother. He has drawn attention to the ways in which an infant's movements change from jerky and uncoordinated to smooth, rhythmic, and circular (Brazelton 1975). These rhythmic features are also characteristic of movements in physical exercise, whether in dance, swimming, or on the exercise bicycle. In a reversal of the original process, the repetition of such movements may evoke the loving and attentive contact which first gave rise to them. In these terms we might regard the pleasure of exercise as object related, involving the recall of some kind of internal object and a memory of relatedness, rather than as primarily narcissistic.

CLINICAL EXAMPLES

If the above considerations are seen as important, the question arises of how to make mental space for a client's disclosures regarding physical exercise, when exploration in therapy sessions reveals no evidence that they are part of an over-controlling, obsessive, or self-punitive pattern. The examples below, taken from small sections of clinical work with clients, may be helpful in this regard.

W has been in therapy twice a week for five years. She was initially suffering from severe anorexia, now very much improved, and more recent work has focused upon her yearning for a sexual relationship. She has had two previous relationships, which she describes as very unsatisfactory both physically and emotionally, and she is able to

recognize that her stated and genuine desire is matched by equally strong feelings of fear and distaste when the possibility of a sexual relationship comes into view.

Against this background, W started to mention swimming quite frequently in her sessions. She would say that she had been swimming, or that she had not managed to keep up with the swimming, or then a few weeks later that she had gone back to swimming. My comments that she seemed to want me to know about her swimming and that swimming had a special importance for her led over time to the emergence of several themes.

W spoke of the caress of the water on her bare skin, of the pleasure of using her body to the full, and of the greater optimism she felt about the future when she managed to swim regularly. She also spoke quite specifically of 'having a feeling of being in her skin'. It seemed that swimming calmed her and kept her from despair at a very difficult and frustrating time. She discovered that swimming was also her way of maintaining contact with her sensual self, and keeping it alive while she was unable to move forward into a sexual relationship. Because of the predominance of physical and primitive elements in sexual relations, the maintenance of this aspect of her sense of self depended upon physical rather than upon verbal self-expression.

These understandings enhanced W's sense of her own resourcefulness and engendered pride in her unconscious addressing of her own needs. The erotic transference to me, evidenced by her desire that I should see and acknowledge this sensual aspect of her, could also be acknowledged, with positive consequences for the therapy.

L had been in deep despair since the death of her mother from an agonizing and disabling spinal cancer. Mourning was complicated by her ambivalence towards her mother, from whom she had not separated very well, and by her father's exclusive focus on his own miserable and bereaved state which kept him from seeing that L had also suffered a painful loss. L's reported decision to join a local gym did not initially strike me as significant, but her repeated and agitated references to her failure to carry through her plan made me rethink and allow time for proper reflection.

A recognized feature of mourning, particularly where the relationship with the deceased person has been complicated, is the fear of being seriously ill and also facing death. Abraham refers to this as 'introjection of the dying object' (Abraham 1924). L's struggle to exercise emerged as representing her struggle to prove that she was not weak or dying, that she had a healthy body, capable of becoming stronger. In raising the subject of the gym with me, she seemed in the transference to be seeking my acceptance of her as somebody with a right to separate from her mother and to live. It became clear that the ambition to join the gym represented the part of L that was able to remain hopeful about the future. When she was able to put her plan into effect, it did in fact mark a turning point for her. The tangible

> outcomes of her work at the gym – weight loss, better energy levels, improved physical health – restored to her some kind of sense of agency and separate identity which she had temporarily lost.

Other themes emerging in the consulting room have likewise indicated links between exercise and emotional well-being. Of interest have been references to the mother's care of the infant's body, including her concern for the infant's health, and to her role in distinguishing between desire and greed and in limiting over-indulgence.

CONCLUDING COMMENTS

Psychoanalytic perspectives on exercise have rightly drawn attention to its evident narcissistic elements, and these may be so predominant as to constitute a problem. In such cases, in Freudian terms, the libido has become fixated on the self (Freud 1914), and the development of healthy interpersonal relations is disrupted. However, a distinction has more recently been made (e.g. Dare and Holder 1981) between pathological aspects of narcissism and its role in appropriate self-interest and self-regard. These healthy aspects of narcissism are seen to contribute positively to the overall level of self-esteem and thus to help rather than hinder the individual in creating satisfying interpersonal relationships. Psychology research on motivation for exercise (cited above) suggests that 'exercisers' may more commonly fall into the latter group than has previously been acknowledged. Reported primary motivations of 'enjoyment', 'having fun', and 'feeling more energetic' do not call up an image of a group of people obsessed with a quest for a perfectly sculpted, admirable and ever-youthful body.

In the above paragraphs, I have also attempted to sketch out ways in which exercise may be understood as object-related rather than (or as well as) narcissistic, particularly insofar as it calls to mind the early relationship with the mother, her encouragement of the infant's steps towards physical mastery, and her handling of the infant's body. It seems upon examination that exercise lends itself readily to symbolization and can carry a rich variety of meanings. In thinking about the role of physical exercise in emotional well-being, we are called upon to consider the whole question of a person's relationship to his/her 'embodiment'. We recognize variations in this relationship, particularly in regard to its pathological manifestations, e.g. the lethargy of the depressed person, or occasionally, the association of

excessive fitness activity with anorexia. The essay represents an attempt to extend this recognition to the embodiment of psychological health.

Much has been written in recent years about the so-called 'mind–body split', with many people apparently regarding the body as a kind of external object, rather than a dwelling place, inseparable from a sense of self. The French have an expression, '*Je me sens bien dans ma peau*' (lit. 'I feel (myself) well in my skin') which captures the opposite of this split, referring instead to the unity of physical and emotional well-being. Among its many positive and negative possibilities, exercise seems to offer the possibility of holding on to or recapturing that sense of 'psychosomatic indwelling' to which Winnicott refers, which in normal circumstance we achieve during our earliest months of life and without which we cannot feel truly whole.

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Maggie Turp, BAC accredited psychotherapist, counsellor and supervisor in private practice; lecturer and researcher at the University of Hertfordshire, Hatfield Campus, College Lane, Hatfield, Herts AL10 9AB. email: Rosecliffe@uk.pipeline.com

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In sickness and in health?

Psychoanalysis and psychosomatics

MAGGIE TURP

ABSTRACT This article revolves around the question of physicality and its relationship to emotional health. Several different perspectives on the mind-body relationship, from within popular culture, philosophy and psychoanalytic literature, are compared and contrasted. The author then suggests ways in which psychodynamic insights might more effectively be brought to bear upon benign and beneficial aspects of bodily expression and offers illustrative clinical material.

KEYWORDS · Health, popular culture, complementary medicine, exercise, psychosomatics, psychoanalysis

The first section of this article maps out a growing preoccupation within popular culture with matters of the body. The second reviews some historical and contemporary perspectives within psychoanalytic thinking with regard to the mind/body question. The third constitutes an illustrative case study. In parallel with these three strands, the qualitative analysis rests on a triangulation of perspectives: testimony and biographical material, a selective literature review and case study material.

The final section argues the advantages of developing a broader frame of reference for psychosomatics within psychodynamics, such that functions and meanings of popular physical activities and complementary therapies might be considered alongside the functions and meanings of psychosomatic symptoms and disorders.

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POPULAR CONSCIOUSNESS AND PSYCHOSOMATICS

Popular culture offers us windows on to ourselves at our least self-conscious, as our preoccupations emerge in songlines, television programmes, magazine articles and chosen leisure activities. Currently, these windows open on to a multiplicity of aspects of physical indwelling. Where there are evident overtones of pathology, our understanding is much enhanced by psychoanalytic theory. For example, much work has been done on women's preoccupations with weight and dieting, and the toll that this exacts when it becomes extreme and manifests as a serious eating disorder is well documented. Apparently, cosmetic surgery has recently become the fastest growing branch of medicine in the USA. In an article on face lifts, 'The skull beneath the skin', Joanna Briscoe (1997) notes 'the body's increasing mutability and the growing readiness to cut it open for aesthetic purposes'. This is an example of a popular trend, which must, I believe, be regarded as pathological. Many psychodynamic practitioners will have encountered in clinical settings the tendencies which Briscoe draws out – the objectification of the body, the masochism, the flirtation with self-harm, the insecurity with regard to one's intrinsic worth which can fuel a narcissistic quest for agelessness and beauty.

However, newspapers and magazines also attest to a growing concern with what Winnicott called 'psychosomatic integrity', with a desire for a full sense of self grounded in the physical. Articles on complementary medicine and meditation have found a place in mainstream journalism. Such articles usually claim tangible benefits for the practice described: for example, diminished stress levels or enhanced immune function. While many such claims remain unsubstantiated, some confirmatory research findings have emerged, in the area of what we might call 'beneficial psychosomatics'. For example, there is evidence that massage can help premature babies to gain weight and to thrive (Bausch 1990). In view of the considerable psychoanalytic focus on early infant development, the subject of touch, and the part it plays in our movement towards and maintenance of a full sense of physical indwelling, is a particularly fitting one for fuller psychoanalytic investigation. Research into the impact of physical exercise on emotional well-being is considered in a previous article (Turp 1997), and I have argued that in this area also there is evidence of 'beneficial psychosomatics' in the psychoanalytic sense. Among other possibilities, sport and exercise may call to mind maternal handling and ward off a tendency for splitting between psyche and soma.

Alongside more general articles are frequent biographical accounts by people who have become consciously active in a battle against physical illness. For example, Kathy Acker wrote in the *Guardian* (1997) about her experiences and thoughts on being diagnosed with breast cancer and undergoing a double mastectomy. After the operation, she was told by her surgeon that there was nothing she could do by way of self-help to reduce the 40 per cent chance of a recurrence of the cancer. She wrote:

> I realised that if I remained in the hands of conventional medicine, I would soon be dead, rather than diseased, meat. For conventional medicine was reducing me, quickly, to a body that was only material, to a body without hope and so without will, to a puppet who, separated by fear from her imagination and vision, would do whatever she was told.
> (Acker 1997)

The phrase 'dead meat' seems to reach to the heart of widespread changes in attitude. We have entrusted our health care to trained professionals for many decades, but now seem more minded to assume responsibility and control in relation to our bodies. This tendency surfaced in the 1970s in feminist struggles relating to the 'right to choose' whether or not to become a mother, to choose the circumstances of giving birth and to reclaim full ownership of one's body within a sexual relationship. Over time the tendency away from idealizing the expert as omnipotent has become much more widespread, among men as well women. Articles appear about 'buddying' or group formation for the purpose of self-examination and early detection of prostate cancer, and newsagents' shelves sport several 'Men and Health' magazine titles. As well as wanting to take more control over their own health, people increasingly assert their right to know their prognosis, even to decide the time and manner of their own death. In some countries a modification of legal frameworks has reflected such desires, as in the legalization of euthanasia under certain circumstances.

Because psychodynamic theory is so strongly informed by clinical experience, by the problems which clients bring to clinical settings, its insights relate particularly to psychosomatic disorders and lack a balancing focus on psychosomatic health. As popular interest has expanded to include health enhancement, Eastern philosophy has been adopted in some quarters as a more attractive frame of reference. Offering numerous concepts of 'body/mind unity' and 'lived body', it has appealed to many complementary health practitioners and humanistic therapists. Practices such as Tai Chi and Yoga offer

the opportunity to build or enhance a proper sense of inhabiting the body, and acupuncture, Chinese medicine and Ayurvedic medicine all stress the importance of emotional factors in physical well-being.

What a psychoanalytic account might offer in addition is a mapping of adult on to childhood experience and an understanding of the elaboration of an expressive physical self in the context of early experience. It also offers the possibility of remaining within a linguistic idiom similar to that spoken by most clients. To adopt an 'Eastern' frame of reference would not only lead inevitably to increased communication difficulties, but would also distance clients from familiar phrases and sayings replete with resonance of their early years. A more fruitful direction may be to explore the full potential of the language of the everyday experience, the language of story-telling, which is also the language of the therapeutic encounter. In contrast to a formal or scientific idiom, such language does offer a rich variety of expressions attesting to psychosomatic unity. For example, we may describe ourselves and others as 'broken-hearted', 'brimming with happiness', 'puffed up with pride', 'rigid with terror', 'gob-smacked' or 'footloose'. When a client speaks in this way, he or she seems to gesture towards a felt link between corporeal reality and imaginative life'.

PSYCHODYNAMIC PERSPECTIVES ON PSYCHOSOMATICS: SOME HISTORICAL AND PHILOSOPHICAL CONSIDERATIONS

Psychoanalysis has been involved with psychosomatic distress from the very beginning, when Freud first advanced his project on the basis of successful treatment by psychoanalysis of physical ('hysterical') symptoms which had no apparent organic underlay in the famous case history of 'Anna O.' (Freud and Breuer 1895). The part of the psyche designated by Freud as the id was most clearly of the body and rooted in biological drives, but Freud also asserted that the ego 'is first and foremost a bodily ego' (Freud 1923).

There has been considerable debate (e.g. Ellenberger 1970), regarding the extent to which Freud did or did not step outside the dominant philosophical and scientific frameworks of his time. It is clear that those were the frameworks primarily available to him for articulating his discoveries, and certainly the only ones to offer him a convincing voice *vis-à-vis* the professional audience he wished to persuade of the legitimacy of his project. As a result, Freud's

formulations tend to be couched in the language of 'mental mechanisms' and models are offered involving 'hydraulics' and 'sums of excitation'. Such language has not readily lent itself to thinking in terms of one 'embodied self'.

Over time there has been a shift within psychoanalysis, particularly in Britain, towards a level of theorizing much closer to actual clinical observations. Such a shift of emphasis gained ground via the work of Melanie Klein, 'who was inspired to watch and listen to the detail of small children at play' (Miller *et al.* 1989). What Klein and her colleagues observed convinced them that the mental activity of infants from the earliest days involves unconscious phantasies of relationships with objects. These are rooted in the experience of the body and its activities and play a key part in building the infant's view of the world: 'Unconscious phantasies are experienced in the first instance as bodily sensations, later as plastic images and dramatic representations, and eventually in words' (Isaacs 1948).

Klein herself wrote about a hypochondriacal patient whose attitude to his physical inside objects (organs) changed in analysis alongside a change of relationship to people in the outside world, showing a parallel shift away from suspicion and paranoia towards care and concern (Klein 1959). The implication is that the patient relates to these internal organs as if they were people inside him, and that these physical aspects of his internal world are also significant aspects of his sense of self.

D.W. Winnicott observed many mother–infant dyads in the course of his work as a paediatrician. Perhaps for this reason, his theories evidence an unusual emphasis on health as worthy of study in its own right and as more than just an absence of pathology:

> In health the use of the body and all its functions is one of the enjoyable things, and this applies especially to children and to adolescence (1986[1967]: 29).

During his long writing career, Winnicott contributed many thoughtful passages on the relationship between psyche and soma. In one of many references to the psycho-somatic partnership he refers to Heidegger's notion of:

> 'What might be called "in-dwelling": the achievement of a close and easy relationship between the psyche and the body, and body functioning'
>
> (Winnicott 1965: 68)

In his invocation of Heidegger's work, Winnicott locates himself within a phenomenological rather than a dualistic tradition. His work offers rich descriptions of the ways in which the body becomes inhabited and the part that physical handling during infancy and childhood plays in this process. Comparing Winnicott to Klein, Adam Phillips writes:

> Winnicott put at the centre of his developmental model not a mythic conflict between incompatible forces but 'the localization of self in one's body'. . . . For Winnicott, there was the body at the root of development out of which a 'psychosomatic partnership' evolved. The self was first and foremost a body self and the 'psyche' of the partnership 'means the imaginative elaboration of somatic parts, feelings and functions, that is, of physical aliveness'.
>
> (Phillips 1988: 78)

As always for Winnicott, the mother's role is crucial:

> This natural tendency to integrate is made possible by the mother's care in which the infant is kept "warm, handled and bathed and rocked and named"
>
> (Phillips 1988: 79)

In the area of psychosomatic disorders, a key and extremely valuable text is Joyce McDougall's *Theatres of the Body: A Psychoanalytical Approach to Psychosomatic Illness* (1989). As the subtitle makes clear, the focus is upon the pathological. 'Theatres of the body' are theatres of illness, pain and perhaps tragedy. Theatres of celebration of the body or of recovery from trauma involving bodily expression are not included within this traditional understanding of psychosomatics. McDougall draws attention to the early 'infans' state, meaning literally 'without speech', and to the infant's dependence upon the body for self-expression. She succinctly describes an adult patient's psychosomatic disorder as 'an attempt to take flight from what she could neither contain nor elaborate' (McDougall 1989). McDougall's work amply testifies to the capacity of psychoanalytic psychosomatics to illuminate the communicative value of many symptoms and physical acts. Such communication is further illustrated in more recent literature, for example in a paper entitled 'Attacks on the body' which describes self-injury as 'a metaphor for psychic distress'. Here, Dawn Collins writes of a young woman who repeatedly scratches two patches on either side of her neck until they are raw and bleeding. Hospital records reveal that the client has suffered several attempts at strangulation, which she herself cannot clearly recall. Collins observes:

> It is as if the trauma, despite the split-off affect and memory, remains located and inscribed in the body. . . . It may be that embedded in all acts of self-injury are clues to its meaning, albeit in a disguised term and often not immediately available to consciousness.
>
> (Collins 1996: 470)

Another recent paper by Elisha Davar entitled 'Surviving or living?' refers to:

> Psychosomatic illnesses, eating disorders, something where psyche and soma get tangled up so that body representation is used as a vehicle to express anxieties and feelings is a likely consequence of needing to contain the uncontainable.
>
> (Davar 1996: 307)

Without arguing against the pertinence of the observation, I am troubled by the implication that psyche and soma are only 'tangled up' in situations of sickness and disorder. How can we conceive of them not being tangled up – in conversation, in gesture, in dance, in a game of tennis and in every aspect of living? John Heaton has observed:

> In our everyday activities we do not experience our minds and bodies as being distinct separate things. When we sneeze or laugh we do not say "my body sneezes" or "my mind laughs". Such language sounds false and artificial.
>
> (Heaton 1967: 216)

Heaton goes on to argue against the absurdity of the original split. In his view, it is only our ever-present awareness of our body which gives us a sense of being 'here'.

> It is only because we are embodied selves that we can apprehend external objects at all for the fact of embodiment makes it necessary for us to observe objects from a place and it is this that gives them their objectivity.
>
> (Heaton 1967: 217)

Here we are at an interface between philosophy and psychoanalysis and may note how developments in social theory and philosophy have both encouraged and reflected shifts of perspective within psychoanalysis. Moves away from a medical model have a background in changes in our perceptions of hard science, and in the different ways which we have come to understand what might constitute a science of the mind. Thus the reductionist endeavour, expressed by Descartes as 'to divide each difficulty I should examine into as many parts as possible, and as would be required the better to solve it' (Descartes 1954), has fallen from favour. As psychoanalytic authors

express their allegiance to other perspectives on thought and knowledge, the opportunity arises to reconsider the mind–body question.

For example, in recent years, psychoanalysis has been much influenced by hermeneutics (see Rustin 1991), which poses future-oriented questions, relating to meaning and purpose rather than to cause and aetiology. What is a symptom/self-injury/eating disorder *for*? What is the person's subjective experience of it? What is being communicated? Such questions may also be put in relation to activities such as physical exercise, dance, meditation and massage.

While maintaining and building on a strong theoretical tradition, contemporary post-Kleinian developments have included the introduction of infant observation as a key element in psychoanalytic training. As a consequence, theory is increasingly informed by observations of normal development, as exemplified by the contributions of Esther Bick, Martha Harris (1978) and others. To undertake infant observation is to be in the presence of a manifest physical–mental continuity:

> [For example,] the physical sensations and experiences of a baby are seen as part of a unified continuum of physical and mental states. The significance for observers of a baby's sense of physical togetherness, or panic, or attachment through sucking (or biting) to the mother, is that it is expressive of a baby's whole state of mind/body, not a physical action alone.
>
> (Rustin in Miller *et al.* 1989: 62)

The method of infant observation is primarily phenomenological, involving close attention and description and with theory taking a second place. Such an approach offers a rich frame of reference for describing physical indwelling in both sickness and health. In addition, and not only within the field of infant observation, many contemporary analysts (e.g. Symington 1986) reflect in their work and writing a shift away from thinking in terms of grand theories and mental mechanisms. Claims with regard to truth, reality and universality have been widely recognized as problematic as evidence has emerged of the degree to which 'identity' is socially constructed and shifting in its nature.

I set out below a possible frame of reference for thinking about the mind–body relationship in phenomenological terms, which derives from Roy Schafer's work (1992). Schafer distinguishes between *actions* and *happenings*. Actions may be conscious or unconscious and include behaviour, perceiving, fantasizing, remembering, defending, loving and, indeed, 'everything that people may be said to do'.

Happenings are 'those events in which one's human agency plays no discernible or contextually relevant part, for example a rainstorm or receiving a mis-addressed letter a week late' (Schafer 1992). Of course, the dividing line between the two is less clear than these quotes suggest, and intrapsychic struggles regarding the nature of actions and happenings are central to both theory and practice in psychodynamics. Not uncommonly, we encounter clients who, in their own minds, are responsible for absolutely everything that has ever impinged upon them and others who feel they have played no part at all in what has come their way. Dilemmas around distinctions between actions and happenings also find expression in psychosomatics when, for example, people regard themselves as either entirely 'subject to' – victims of bacteria and viruses who play no part in their own susceptibility – or alternatively as omnipotent – bringing illness upon themselves through named or nameless imagined transgressions.

Schafer proposes a further division of 'actions' into 'showings' and 'tellings'.

> Psychoanalysis is conducted as a dialogue. . . . In this dialogue, actions and happenings (for example, traumatic events) are continuously being told by the analysand and sooner or later retold interpretively by both analyst and analysand. Closure is always provisional to allow for further retellings. In many instances the *tellings are nonverbal enactments: showings that are yet to be transformed into tellings.*
>
> (Schafer 1992: XV)

Julia Buckroyd's work with women with eating disorders seems to articulate possible routes in practice for moving from a 'showing' to a 'telling', weaning a person away from an exclusive dependence on physical expression of feelings towards an ability to express emotions in words:

> An eating disorder is an expression of feeling. What I have done is to work with young women in groups finding physical and non-verbal expression for feelings and then talking about what we have done together. In that way, I have tried to provide a bridge between the physical and the verbal.
>
> (Buckroyd 1994)

Dr Buckroyd seems to be saying that, in the case of an eating disorder, something is so firmly lodged in the body that a transitional stage is needed before verbal elaboration and working through can begin. She has introduced work with paint and clay to offer such a 'bridge' between physical and verbal:

> The activity of art may be analogous to the activity of eating disorders in that it can be experienced as another way to express oneself and one's emotions. However, because in art there is an end product, physically separate from the doer, it has the potential to provide the break in the repetition of the somatic means of self-expression of an eating disorder. The art work is there, with the potential to be looked at and talked about as a symbol of the self, leading to more self-awareness and a bid for change.
>
> (Buckroyd 1994: 107–8)

In the case of eating disorders, symbolization of affect via the body is problematic, particularly in its rigidity, whereby the client is stuck in a cycle of somatic repetition. But, I would argue, in many instances 'showings' may healthily take up a place alongside 'tellings', offering alternative paths for self-expression with a particular eloquence of their own. From this perspective, we can perhaps view sport or dance or yoga with less suspicion, regarding the body, rather in the way we regard dreams, as a potentially creative site of symbolization, elaboration and self-expression.

CASE STUDY

G, a client in her early thirties, while attending regularly for twice-weekly psychotherapy, also took up in succession yoga, aerobics, massage, aromatherapy and 'body-brushing'. This latter practice required her to brush her whole body four times a day for at least five minutes. Her strict adherence to such regimes kept her from attending to quite serious problems – a pressing need to plan future career developments, a difficult and unsustaining sexual relationship and a poorly understood aversion to speaking to her mother on the telephone or visiting her.

Coming from a well-to-do family, G had felt close to her father, a successful businessman, but rather competitive with her mother. It emerged that she was sent to boarding school when she was 7. On this subject, she was rather reticent. She reported that the start had been rather difficult but that eventually she did well and became head girl.

This client favoured a vague language of 'good karma' and mystical thinking, and I was aware of a great deal of splitting and evasion inherent in her myriad therapeutic activities. Quite probably she was seeking to diminish her vulnerability by spreading the risk of disappointment between so many different practitioners. Also, she might have been feeling quite competitive with and/or envious of me, and sabotaging our work as a consequence. Nevertheless, I felt

it important to reflect also upon the particular form of these activities. Was there a more specific message in these 'showings', and, if so, what did they express and what might the client unconsciously intend in describing them to me?

I encouraged her to tell me more and her associations enabled us to discover links between her physical strivings and her early experience, which proved very helpful. At one point I remarked that, in describing her physical activities, she seemed to be drawing my attention to some kind of loss or 'lack' in relation to her body. This intervention called to mind memories and feelings, long forgotten, of being driven to and then left at boarding school. For the first time I heard how miserable she had felt in a completely new environment without familiar figures, of how she had refused to eat to begin with and been made to sit in front of the cold congealing meal for what seemed like hours. I commented that she did not seem to have received the support or the physical love and cuddles that a little girl would normally continue to enjoy well beyond such a young age. As G became more in touch with feelings of great sadness and loss, she was able to cry and to speak in an unusually direct manner about her sense of physical abandonment and her desperation to be held and comforted. The sense of sadness and vulnerability which she expressed later linked with dream material of arriving in class for a lesson only to discover herself naked and shivering in front of her schoolmates.

As we reflected upon these matters during sessions, the need to repeat such communications in a somatic form seemed to diminish. The succession and variety of activities, which had seemed to signify a questing for physical answers to emotional problems, faded away as G's capacity for psychic elaboration improved. She continued with body-brushing and with yoga, but these activities lost their obsessive quality and enjoyment became more evident. At the same time, she became able seriously to address the difficult issues which had caused her to seek counselling.

PSYCHOSOMATIC ILLNESS AND PSYCHOSOMATIC HEALTH: DEVELOPING A MORE INCLUSIVE FRAME OF REFERENCE

In previous work (Turp 1997), I have endeavoured to show that vigorous and rhythmic body movements – for example, those involved in dance, swimming, walking, climbing and sport – have

the potential to re-create and stand as metaphors for comforting and containing experiences from the past. Where this is the case, they do not invite a 'pathological' label and seem to bring psychological benefits that go beyond any compensatory function. Thus I have argued that the usefulness of such activities not only includes but also transcends their capacity to contain anxieties which might otherwise prove overwhelming. Similarly, in the above example, it seems to me that both the comfort provided by the physical activities themselves *and* their imaginative elaboration in counselling contributed in some measure to the client's move towards greater psychological well-being.

The terms 'showing' and 'telling' offer one possibility of including considerations of symptoms and disorders and activities – such as running, sport or body brushing – within the same framework. 'Showings' may represent the pathology of being caught up in an obsessive cycle of somatic events, they may communicate attempts to contain anxiety or they may stand as genuine endeavours to repair early damage or injury, perhaps caused by inadequate or insulting handling during infancy. The case for linking them together resides primarily in their common relationship to our earliest, non-verbal, mode of communication, which is only partly superseded by language in adult life. Viewed from this perspective, there is scope for extending the term 'psychosomatics' to apply to beneficial as well as pathological instances of expression and communication via the body. An expanded psychosomatic framework along the lines suggested would need to recognize that activities such as aerobics or dance *may* have pathological overtones, as when undertaken in a narcissistic spirit of objectifying the body and denying its limitations. Alternatively, they *may* be psychologically beneficial, expressing a desire for a fuller sense of physical indwelling, or they may evidence a mixture of motivations.

I have been much influenced in my researches by the continuing appearance within clinical settings of all kinds of concerns with mind–body questions, with physical or psychosomatic illness, with self-harm and eating disorders, and also with quests for wholeness and a full sense of self grounded in the physical. I hope my contributions may provoke greater thoughtfulness with regard to the various ways in which each of us inhabits and views his or her physical self and help us as practitioners to be more attuned to aspects of our clients' communications which touch upon these matters. Through closer reflection upon such concerns, it may be possible to build upon the

established value of psychoanalytic thinking in addressing psychosomatic disorders, and to bring its insights more widely to bear upon other aspects of our ever-present 'embodiedness'.

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Since the completion of this article it is with regret that I have learned of the death of Kathy Acker on 29th November 1997.

Maggie Turp, Researcher/Lecturer, Department of Counselling, University of Hertfordshire, Meridian House, The Common, Hatfield, AL10 0NZ, E.Mail: rosecliffe@psilink.co.uk

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Encountering self-harm in psychotherapy and counselling practice.

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ENCOUNTERING SELF-HARM IN PSYCHOTHERAPY AND COUNSELLING PRACTICE

Maggie Turp

ABSTRACT This paper offers a perspective on self-harm as encountered by psychotherapists and counsellors practising in non-institutional settings. The author notes that the background of epidemiological information, which might inform clinical practice with these clients, is far from satisfactory. Difficulties in establishing an accurate epidemiology of self-harm are considered. Some common responses to incidents of self-harm are then explored, with particular reference to countertransference issues and the lack of containment (Bion 1962) available to practitioners in some professions.

A brief overview of theoretical perspectives on self-harm is followed by a more detailed account of the contributions of Welldon (1988), Bion (1962, 1967) and Winnicott (1949, 1962, 1967). The author describes and discusses her work with clients who harm themselves, drawing primarily upon the concepts of 'projective identification' (Klein 1946), 'containment' (Bion 1962) and 'psychosomatic indwelling' (Winnicott 1967).

Methodology

The material presented below is taken from clinical work, from psychoanalytic texts and from the findings of a few larger surveys, for example, Harlow and Harlow 1962, Favazza 1987, 1989, Hopkins 1990 and Arnold 1995. As Michael Rustin has written:

> ...the control of the outside world routinely sought by normal sciences is made impossible and undesirable for psychoanalysis by its distinctive commitment to the autonomy of its human subjects. (Rustin 1996, p. 527)

Nevertheless, the interweaving of several different kinds of 'data', via the process of 'triangulation' (Denzin 1970), adds to the reliability of the qualitative research methods employed.

Introduction

The paper begins to address theoretical and clinical issues raised by people who harm themselves whilst maintaining seemingly normal lives in the community. I refer to them as a 'sub-clinical' population of individuals who self-harm. Typically, they are involved neither with psychiatric services nor with the criminal justice system. Because literature on self-harm has focused primarily on self-harm as encountered in institutional settings, among offenders or within psychiatric services (Lacey & Evans 1986; Frances 1987; Walsh & Rosen 1988; Favazza 1989a, 1989b; Potier 1993) rather little has been written about this client group.

Part 1 considers the linked questions of definition and epidemiology of self-harm. The existing DSM-IV (APA 1994) entry on self-harm locates it as a sub-section of

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MAGGIE TURP lectures and researches at the University of Hertfordshire and is a psychotherapist and supervisor in private practice. She is engaged in ongoing studies at the Tavistock Clinic, London. Address for correspondence: 73 Torbay Road, London NW6 7DU.
Email: MaggieTurp@aol.com

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borderline personality disorder. Along with many colleagues, I have found this definition inappropriate for 'sub-clinical' self-harming clients encountered in counselling or psychotherapy practice. I suggest an alternative, more inclusive definition of self-harm and support Tantam and Whittaker's (1992) call for the recognition of a 'deliberate self-harm syndrome'.

Inevitably, the absence of an agreed definition of self-harm with broad applicability has adverse consequences for the development of an accurate epidemiology. The problem is compounded by the large variety of professions encountering self-harm and the lack of a central logging system for incidents.

Practitioners in a variety of professions, for example, nurses in accident and emergency units and teachers, are called upon to deal with self-harm. Unlike counsellors and psychotherapists, they may receive little or no supervision or support in negotiating their own emotional responses to this disturbed and disturbing behaviour. With no setting available for the negotiation of countertransference issues, practitioners are likely to have difficulty in offering containment and in feeling contained themselves. Part 2 considers some of the consequences of this situation, including the immediate consequences for the person who self-harms and the likely consequences for subsequent work in counselling or psychotherapy.

Self-harm can be understood in many different ways. Some accounts focus on antecedent causes, some seek to locate self-harm in terms of psychiatric diagnoses, whilst others concentrate on the function and meaning of self-harming behaviour. Part 3 of the paper offers a brief overview of theoretical perspectives, considers the growing 'family' of disorders described as psychosomatic and addresses the question of gender differences in self-harm, with particular reference to the work of Welldon (1988). Parts 4 and 5 describe relevant work by W. Bion (1962, 1967) and D.W. Winnicott (1962, 1967) in more detail and include illustrative clinical case material.

1. Definition and Epidemiology of Self-Harm

Self-harm is a multi-professional issue. Exact incidence figures will always elude us since many people who self-harm do not report their injuries. Those who do so may seek assistance from, or be referred to, a variety of different practitioners – nurses in accident and emergency, teachers, GPs, social workers, probation officers, community psychiatric nurses, psychiatrists, psychotherapists or counsellors. As no central logging system exists, there can be no consistent monitoring across different professional groups of incidence or severity of self-harm. We are in the rather unsatisfactory situation of having a sense of an increased and increasing incidence of self-harm, with only very partial epidemiological data to rely upon. This is particularly the case in relation to self-harm outside institutional settings.

A serious effort to improve this situation would involve addressing issues of definition, since epidemiological studies cannot progress satisfactorily where definitions are inadequate. At present, different terms – for example, self-harm, self-injury, self-wounding and self-mutilation – are selected by different authors. Often the parameters of the terms and areas of difference and overlap are far from clear. In my view, this confused picture is linked to the absence of a satisfactory definition of self-harm, applicable both to self-harm in institutional settings and to self-harm in the 'sub-clinical' population frequently encountered in counselling and psychotherapy.

The DSM-IV (APA 1994) uses the term 'self-mutilation' rather than 'self-harm' and includes a listing and description (only) within the 'Borderline Personality Disorder' entry:

> Complete suicide occurs in 8% – 10% of such individuals, and self-mutilative acts (e g cutting and burning) and suicide threats and attempts are very common. . Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil. (DSM-IV 1994: 651).

The common confusion which exists between self-harm and suicide attempts is compounded here, in the comparison of self-harm with 'complete suicide'. Most authors do not regard self-harm as 'incomplete suicide'. For example, Favazza (1989a) defines self-injury as 'the deliberate alteration or destruction of body tissue *without* a conscious attempt to die' and (1989b) as 'a purposeful, if morbid, act of self-help'. Such descriptions are in line with my own clinical experiences and with the responses of 78 women participating in research conducted by L. Arnold for the Bristol Crisis Service for Women in 1994–95, referred to hereafter as the 'Bristol Survey'. Among the women who volunteered to take part in that research, many spoke of self-harm as an *alternative* to suicide and/or to mental breakdown, which signified a kind of psychic death.

> It's a solution that means I'm not going to flip our completely and kill myself. (Woman E, Arnold 1994)

Another problem with the DSM-IV definition is its non-applicability to self-harming individuals who do not meet other diagnostic criteria for a borderline personality disorder. Tantam and Whittaker (1992) argue that there is no personality disorder unique to self-wounding and suggest that 'the attribution of upsetting behaviour to abnormal personality tends to blunt the normal caring response'. They suggest instead the formulation and recognition of a separate 'deliberate self-harm syndrome'.

As well as having implications for practitioner response, specifying such a 'syndrome' might assist epidemiological studies and underpin the exploration of links with other pathologies, for example, eating disorders and substance and alcohol abuse. Several authors (Krystal 1978, 1988; McDougall 1974, 1989; Arnold 1995) have noted overlaps between these various pathologies. They seem to belong in the same 'family', in that each involves distortions of somatic self-expression and conscious behaviours antithetical to a normal concern for self-conservation and self-care.

Psychosomatic disorders might be seen as belonging on the fringes of this 'family' also, similar in their excessive reliance upon somatic aspects of self-expression but different in the unconscious rather than conscious expression of disturbance or distress. These matters are considered further in Part 3 below.

In putting forward my own definition, I have chosen to use the term self-harm. Although I most often encounter self-injury, particularly in the form of self-cutting, I prefer not to exclude other behaviours – for example, driving with deliberate recklessness – which knowingly invite physical injury and which typically arouse similar feelings of shock and alarm in those who witness them.

Defining self-harm brings me face to face with a number of complexities. Firstly, there are anthropological issues to be considered. An action regarded as self-harm in one culture may be regarded as entirely normal, or even socially prescribed in another. Favazza (1989b) provides a long list of 'culturally sanctioned mutilations', including

Chinese foot-binding, Moroccan head-slashing and many others. Secondly, behaviour which we do not normally regard as self-harm on account of its normality and social acceptability, for example, heavy smoking, is often considerably more damaging to physical health and ultimately life-threatening than, for example, self-cutting:

> A number of women commented on the varying degrees of social acceptability of different forms of self-harming behaviour, feeling it to be unfair that self-injury seems to be so much more harshly viewed than, say, getting drunk and picking a fight, whilst activities such as chronically overworking are socially applauded. (Arnold 1995: 9)

Whilst I do not think that self-harm should be 'harshly viewed', I do not wish to ignore the fact that its tendency to provoke strong feelings in others is part of its essence. The 'shocking' quality is intrinsic to the behaviour, serving to communicate the loss of a capacity to process emotions and impulses in more thoughtful or socially acceptable ways.

Bearing these points in mind, I offer the following descriptive definition of self-harm. It is behaviour which (1) intentionally and evidently compromises or overrides a person's normal tendency to conserve and take care of him or herself; (2) has an intense or extreme quality which evokes strong feelings in onlookers, (e.g. concern, dismay, alarm, horror, guilt, anger, sadness, disgust); and (3) is not first and foremost an eating disorder or an abuse of drugs or alcohol (although these may also be present). As we cannot quantify 'strong feelings', there will inevitably be incidents at the margins of this definition which some psychotherapists regard as self-harm and others do not.

In my psychotherapy practice, approximately 10% of clients (4 out of 40) who referred themselves between 1991 and 1997 eventually spoke about self-harming behaviour, as defined by the above criteria. 'Eventually' is a key word as disclosure of self-harming behaviour is often inhibited by previous negative responses. None of these clients mentioned self-harm until a therapeutic alliance had been established. Two general practice counsellors (C. Seigal and M. Colah) in supervision with me have also collated figures. As they practise short-term psychodynamic counselling, they see many more new clients during the course of a year than I do. Consequently, they have been able to provide a breakdown of male and female incidence rates. Among 64 new clients seen between January 1997 and January 1998, the incidence of self-harm, as defined by the above criteria, was 15% among women and 5% among men.

2. Common Responses to Self-Harm

For many practitioners, as well as for friends and relatives, self-harm poses immense emotional challenges. Self-cutting and self-mutilation, in particular, may arouse feelings of primitive horror which can be very hard to bear. Furthermore, efforts to help may be deliberately spoiled by the patient. The nurse carefully stitches a self-inflicted cut but the patient returns two hours later with the stitches pulled out. The counsellor spends an hour with the client, giving her all in an effort to mitigate the evident emotional distress. Nevertheless, the client arrives for the next session with new bandages on her arms.

> Mostly I cut myself with broken glass. Sometimes I'd hold a cigarette or a match flame against my arm. When I haven't wanted to leave scars I've done things like smash my arms against the banisters again and again until they were all bruised. (Woman A, Arnold 1995: 6)

When a person has cut, bruised, burned or poisoned herself, or interfered with wound healing or brought injury upon herself through reckless behaviour, it can be difficult not to react in a judgmental or even punitive manner. The action seems so wasteful, so shocking. Unless we are well supported in our work, we will tend to defend ourselves against the levels of distress involved and such defensiveness will inevitably interfere with our ability to remain thoughtful in the face of the self-harming behaviour. When incidents of self-harm impinge upon a practitioner who is inadequately supported and supervised, we have the makings of a situation where treatment is unlikely to be therapeutic and may be less than humane. In my experience, clients have rarely encountered a sympathetic professional response prior to seeking psychotherapy. In addition to emotional coldness and a dismissive attitude, they often describe wounds being sutured without anaesthetic or 'treated' by the application of methylated spirits.

> Over and over again women told us of being criticized, ignored, told off, dismissed as 'attention-seeking', 'a nuisance' or 'wasting time'. Many were derided as being 'childish'; one 15-year-old was told to 'grow up'. Some felt they were punished for being 'a self-harmer', sometimes being made to wait far longer than other patients for treatment, refused treatment altogether or treated cruelly, for example, being sutured without local anaesthetic. (Arnold 1995: 18)

The emphasis on supportive supervision and personal psychotherapy, which is intrinsic to a psychoanalytic approach, does not exist within most professions. Many practitioners outside psychotherapy settings have no formal context for identifying and processing their countertransference feelings. It is unsurprising, therefore, that they are sometimes unable to remain thoughtful and empathic in the face of feelings aroused in them by the patient who self-harms. The failure of containment (Bion 1962) which is expressed in the act of self-harm thus has a tendency to be echoed in and compounded by practitioner reactions.

In some institutions, practitioner countertransference translates into and is supported by 'behavioural' formulations which advise *against* caring attention to the injuries or empathy with the feelings which underlie them, on the grounds that such attention will offer a 'positive reinforcement' and make a repeat episode more likely. Whilst this approach may offer practitioners a rationalization for punitive behaviours, there is no evidence that it has a beneficial impact on patient behaviour:

> I used to see a clinical psychologist but she was very unsympathetic. She thought cutting myself was an attempt to manipulate her and that it was disgusting. She used to make me show her my arms to prove I hadn't hurt myself, which is when I started cutting my legs. (Woman D, Arnold 1995: 18)

> I wanted to go to the day hospital, but they said they wouldn't take me until I'd sorted out my eating and my cutting. I thought 'If I could do that then I wouldn't need to come here'. (Woman C, Arnold 1995: 19)

Behavioural interventions, particularly where used alone, may involve significant dangers for the patient. Several women in the Bristol Survey indicated that they resorted to other, potentially more dangerous behaviours, if they did not harm themselves:

> I have periods of not eating. It helps me cope if I'm not cutting. (Woman C, Arnold 1995: 8)

> I still hurt myself in lots of ways, really. Worrying, blaming myself for things, doing too much, not letting myself sleep – they're just as bad for me. (Woman A, Arnold 1995: 8)

Such self-reports throw enormous doubt on the wisdom of attempts to 'programme out' the self-harming behaviour. There is every reason to believe that alternative and more dangerous actions will replace the current mode of self-harm. Freud was keenly aware of 'The Sense of Symptoms' (1916) and warned that symptoms which disappeared were likely to be replaced by other symptoms, unless underlying emotional issues were properly addressed.

When clients describe unsympathetic or retaliatory reactions to self-harm, I feel immensely sad and angry for all involved. We need to develop and communicate a better understanding of the needs of practitioners who encounter self-harm, many of whom do not have the support which would encourage a practice of thoughtfulness. As well as supportive supervision, training which helps practitioners to make sense of the self-harming behaviour they witness is vital. As Bion has described, developing an understanding is in itself containing of anxiety. It offers terms in which one can think about and think through what has happened, rather than feeling that one must *act*, whether in a rescuing or punitive manner. Until there are changes in thinking in some quarters, clients will continue to present for counselling or psychotherapy with a legacy of dismissive or punitive responses and a consequent reluctance to confide in us about their self-harming behaviour.

As counsellors and psychotherapists, our main advantages are a theoretical base with the potential to make sense of self-harm, and a culture which discourages grandiosity and heroism and preaches instead the virtues of supervision and acceptance of limitations. This perspective dates back to Freud's vision of psychoanalysis as a practice in the service of 'transforming neurotic misery into common unhappiness' (Breuer & Freud 1895). Nevertheless, there is little room for complacency. More than once, I have felt my own ability to maintain a therapeutic presence pushed to the limits by a client who self-harms.

3. Theoretical Issues in Relation to Self-Harm

Many theories have been advanced in relation to self-harm. Three prevalent psychiatric approaches have described it as (a) a manifestation of borderline personality disorder (Walsh & Rosen 1988), (b) a disorder of impulse control (Pattison & Kahan 1983), and (c) a multi-impulsive personality disorder (Lacey & Evans 1986).

Psychoanalytic approaches are more concerned with the possible functions and meanings of self-harming behaviour and with the relevance of early experience than with psychiatric classification. Unfortunately, it is impossible to do justice to all of the relevant perspectives in a paper of this length. Favazza (1989a, 1989b) identifies a number of psychodynamic themes, including the need to differentiate ego boundaries, reduction of sexual or aggressive tension (sometimes accompanied by sexual excitement), symbolic re-enactment of oedipal issues and the expression of unconscious rage towards an internalized object, usually the mother.

As well as attending to its inherent qualities, we may wish to consider the siting of self-harm in terms of (i) its relationship to its antithesis, which is self-care, and (ii) its relationship to other disorders. The first of these topics is reserved for Part 5 of the paper. The second brings to mind several recent papers, which have opened out the field of psychosomatics (author italics throughout):

> We suggest that both *self-harm* and *mindless assaults on others* may reflect inadequate capacity to mentalize. Poor functioning of this capacity tends to lead to mental states being

> experienced as physical, in both the self and others, and violence is seen as an attempt to obliterate intolerable psychic experience (Fonagy & Target 1995: 487)

> This paper describes a body of theory which points to the possibility that *eating disorders* can be seen as psychosomatic illness, which is to say a symbolization of affect via the body rather than with words. (Buckroyd 1994: 106)

> My hypothesis is that *self-injury* is a symptom. This symptom may take the place of words, and functions as a means of communication. (Collins 1996: 463)

These developments raise many issues, among them the relationship between conscious and unconscious psychosomatic manifestations and issues of gender. We know that there are statistical overlaps between self-harm, eating disorders, substance and alcohol abuse and violent outbursts (McDougall 1974,1989; Krystal 1978, 1988; Fonagy & Target 1995; Arnold 1995), with women over-represented in the first two categories and men in the latter two. All of these behaviours involve conscious actions which may, however, not be experienced as voluntary. How do we understand these gender differences and what influences an individual's 'choice' of the conscious route, rather than the unconscious route of psychosomatic illness, when psychic events cannot be contained and expressed in words?

One possibility is that the 'conscious route' is characterized by impulsive discharge of sexual and aggressive drives. Some authors have located self-harm primarily as a disorder of impulse control (Pattison & Kahan 1983; Lacey & Evans 1986), but there is also relevant clinical experience (Arnold 1995, author example below) to suggest that self-harm is not always enacted on impulse. Fonagy and Target (1995) offer a more complex account of the evolution of 'non-sadistic' violence towards the self or others, involving (a) the need to defend a fragile psychological self and (b) repeated experiences of aggression:

> A third stage is reached, when self-expression and aggression are associated so regularly that a pathological fusion can occur between the two (self-expression becomes isomorphic with aggression). (Fonagy & Target 1995: 488)

Welldon (1988) presents a unique perspective on self-harm which fully addresses the gender difference referred to above. She notes that the issue is complex:

> At least a three-generational approach is required, and it should include also the variety of social and cultural phenomena that confer importance on motherhood as the main source of power and control available to women. (Welldon 1988: 16)

Welldon regards self-harm as a 'female perverse act'. She sets out the difference between male and female perversions:

> As a clinician I have observed that the main difference between a male and female perversion lies in the aim. Whereas in men the act is aimed at an outside part-object, in women it is usually against themselves, either against their bodies or against objects which they see as their own creations: their babies. In both cases, bodies and babies are treated as part-objects. (1988: 8)

In Welldon's extensive clinical experience, acts of self-harm provide a short-lived feeling of well-being and a sense of relief from mounting anxiety.

> Such apparent sexual acting-out is a manic defence against formidable fears related to the threat of losing both mother and a sense of identity. (1988: 9)

Self-harm has been connected to sexual abuse in childhood (Van der Kolk *et al* 1991; Arnold 1995) and to other traumatic childhood experiences including neglect, emotional abuse and physical abuse. Women participating in the Bristol Survey gave poignant accounts of such experiences:

> My childhood wasn't happy I was the eldest of five, so very soon had to take on the responsibilities of being an adult, taking care of the younger ones My parents didn't get on There would be terrible fights. The house would be smashed up, sometimes there was blood. We also had a fair bit of physical abuse. I was sexually abused, which led to me trying to commit suicide. I ran away constantly. (Woman A, Arnold 1994: 10)

> Sometimes, no one spoke to me for weeks. We would pass on the stairs like strangers. There were never any hugs or love, just ice-cold looks, no conversations. (Woman B, Arnold 1994: 11)

Welldon also describes extremely disturbing infant experiences, which are the particular lot of some baby girls. In these, a female child who is unwanted is not permitted to enjoy a sense of her own development as a separate individual. Instead, she is treated as a part-object, as an extension of the mother. When she becomes an adult, this woman may harm herself or her own children.

> From being victims, such people become the victimizers. In their actions they are the perpetrators of the victimization and humiliation previously inflicted upon them. They treat their victims in the same way they felt treated themselves: as part-objects who are there only to satisfy their whims and bizarre expectations. (Welldon 1988: 9)

The 'victim' in the case of a woman who self-harms is her own body. In her disturbance and in the act of self-harm, a mother may be protecting the alternative part-objects – her children – from destructive and aggressive impulses, which she is unable to manage in other ways.

A counsellor brought to supervision a client who was quite conscious of this dynamic and referred to it explicitly. The client recounted how she had tried to resist the compulsion to inflict a self-injury. She took a knife from the kitchen drawer, replaced it, took it out again, 'hid' it and went out for a walk, before returning and cutting her arm. (The counsellor was reminded of her own efforts to give up smoking, which involved taking out a cigarette and replacing it several times, 'hiding' the packet from herself, and so on.) In this instance, the client believed herself to be in control of the situation, but went ahead and cut herself anyway. She told the counsellor:

> I knew I was on the edge. It was the only way to be sure that I wouldn't start screaming at the kids and slapping them five minutes after they got in from school. I wanted us to have a nice evening.

Winnicott's work underpins an understanding of the possible positive value of self-harm. On the one hand, in common with other psychosomatic symptoms, it expresses a tendency 'not altogether to lose the psychosomatic linkage' (Winnicott 1966). On the other hand, it can be seen as an antisocial tendency, with considerable 'nuisance value', which carries the hope that environmental deficits may eventually be made good:

> At the basis of the antisocial tendency is a good early experience that has been lost Surely, *it is an essential feature that the infant has reached to a capacity to perceive that the cause of the disaster lies in an environmental failure*. (Winnicott 1956: 313)

This overview of perspectives on self-harm is far from exhaustive. Detailed mapping of relevant contributions, of recent developments and of questions outstanding falls outside the remit of this paper.

4. Thinking and Acting

There are many ways of thinking about self-harm and they are not, of course, mutually exclusive. In my own work, I have drawn particularly on concepts offered by Bion (illustrated below) and Winnicott (illustrated in Part 5).

According to the findings of the Bristol Survey, many women harm themselves in order to manage desperate feelings. Self-harming actions enable them to regain some kind of feeling of order and control and they are often able to hold down a job or to care for a family. Like some eating disorders, self-harm seems in these instances to constitute 'a bid for psychic life' (Buckroyd 1994), an alternative, albeit a desperate one, to mental breakdown or to suicide.

The understanding that psychic conflicts and unresolved feelings will somehow find expression has informed psychoanalytic thinking from its beginnings (cf. Breuer & Freud 1895). The flow of blood resulting from self-cutting seems to eloquently express a spilling over of that which cannot be contained. According to Bion (1962, 1967) the capacity to metabolize experiences in non-pathological ways depends upon a capacity for containment, involving the possibility of thinking in the face of distress rather than moving to an immediate evacuation of feelings via action. Crucially, this possibility depends on the responsive presence of a maternal figure with the capacity to think in the face of distress, which in normal circumstances is gradually internalized by the infant.

Faced with a self-harming client, it can be difficult not to express a felt sense of urgency by focusing heavily upon the self-harming behaviour, with a view to its early elimination. If we are prompted to hasty plans of action or verbal retaliation, then we simply play our part in a client's re-staging of his or her early experience of an uncontaining maternal figure. Klein's (1946) concept of projective identification and Bion's (1962) work, particularly the concept of containment, combine to offer a theoretical perspective which supports the difficult work of maintaining a thoughtful and therapeutic presence in the face of desperate actions and feelings. This support was vital to my work with Geoffrey.

> Geoffrey has been coming to see me once a week for six months. He 'self-hits', punching his fist repeatedly against the wall of his bedroom, causing severe bruising and occasional laceration. His attacks on my thinking are relentless and occasionally bizarre.
>
> Following a session in which we did some good work, Geoffrey comes in, sits down, and asks in an innocent kind of tone 'If I were to pick up this chair and throw it through your window, would you be insured for that?' He smiles and gets up out of the chair. At this time, I am working from a consulting room in my home (something which I no longer do). I can hear neighbours in the garden. It is a struggle to stay put and say, 'Let's think for a moment about what you are saying. Last week, I think you felt you had made some progress. You took something away with you, a particular image of yourself as a person bound to a dripping tap in the middle of a desert – unable to move away in case there would be no water anywhere again, ever. Today, you feel quite destructive. You have an urge to spoil the room, to spoil our work together. It's hard for you to hold on to anything good.' Geoffrey says: 'Keep talking. Keep talking. But I bet you're scared.' I say, 'There's a part of you that wants to spoil things

> and a part of you that wants to come through. I can see the sense of both of them but I know which side I am on ' To my relief, Geoffrey sits back down in his chair.

Although I eventually succeed in arriving at some form of words, I am reminded of Eric Rhode's comment that:

> Bion writes with a pioneer's courage about sessions in which the patient's psychopathology knocks all meaning out of the therapist's mind. (Rhode 1993: 504)

Geoffrey's capacity to think and to contain his feelings has been severely challenged from very early on. He was frequently subject to traumatic experiences, which any young child would find overwhelming. In the face of repeated physical abuse, he developed a way of 'disappearing' by freezing himself, stopping moving and breathing when in the same room as his stepfather. As an older child, he sometimes sat in his room through weeks of dark evenings because he was too frightened to say that his light bulb needed replacing. When this was finally discovered, he would be beaten for the stupidity of sitting in the dark and not saying anything.

Thus he knows what it is to have 'the meaning knocked out of your mind', and effectively communicates this experience to me via the process of projective identification (Klein 1946). During this first six months of therapy, Geoffrey is hardly ever able to recall the feelings surrounding such events, let alone to put them into words. Frequently, he can only let me know how he feels by stirring up similar feelings within me.

> *Geoffrey comes in and rounds on me.* 'I've been coming here for over a year, and I'm still no better. I don't do as much punching, but I still haven't got a proper relationship. I'm still glued to that damned dripping tap! I'm still stuck in the same dead-end job! What good is this doing me? Why should I bother to come?' This attack on my competence, on my right to exist is immediately successful. I feel just awful – guilty and inadequate, worthless, a complete fraud. I realize, however, that Geoffrey's assessment is not entirely accurate and that there have been significant changes. For example, he has started to study for a degree and has finally moved out of his mother's home and bought a flat of his own. I say 'I think you want me to know how it feels when all your efforts are for nothing, when no matter how hard you try, it simply makes no difference. You are just seen as a worthless drain on others.' At this, Geoffrey starts to weep. I shift to feeling very warm towards him in the countertransference and the ensuing silence in the room has an empathic and reflective quality.

On the subject of containment and projective identification in infancy, Shuttleworth writes:

> Through projective identification the infant is brought into contact with his mother as a *container* – as an object with a space for the distress which he cannot tolerate, at the same time providing him with the opportunity for internalizing a mother who has this capacity. The fact that his mother's capacities allow her not simply to register the baby's distress but to *think about it* (consciously or unconsciously) and respond in a *thoughtful* way means that she is in a position to modify the demands made on the baby's psyche by distressing experiences and at the same time give the baby his first contact with the human capacity for bearing pain through thinking. (Shuttleworth 1989: 36)

Many people who harm themselves have had very limited experience of containment. As psychotherapists and counsellors, we have the responsibility of creating a context where they can experience what may indeed be their 'first contact with the human capacity for bearing pain through thinking'.

Among the women taking part in the Bristol research, self-cutting was by far the most common kind of self-harm, engaged in by 90% of the women. The matter of the skin and its psychic functions has aroused interest within psychoanalytic theory, perhaps beginning with Winnicott's reference to. 'the perpetual *human* task of keeping inner and outer reality separate yet interrelated' (Winnicott 1953: 230).

Bick has contributed eloquent accounts of the development of a primal skin, which gives an infant a sense of being held together in one piece, and of a toughened and impermeable 'second skin', where an infant suffers from inadequate maternal containment. The relevance of Bick's work to self-harm, particularly self-cutting, merits fuller consideration than space allows on this occasion.

However, I do want to emphasize the *physicality* of self-harm and to give examples of how 'psychosomatic indwelling' (Winnicott 1967) might be specifically attended to in a psychotherapeutic setting. In the next section, I describe conversations relating to a client's attention to or neglect of physical self-care. I am content if such conversations translate into actions outside the consulting room, *where they seem to support a nascent capacity for self-care*. Such a perspective may seem to run counter to my emphasis above on a shift towards thoughtfulness and away from reliance upon somatic functioning. To avoid any confusion, I will emphasize a distinction between two kinds of physical activity: *activity which is inimical to and stands in the place of thinking; and activity which is accessible to thought and which links to actual memories or to 'memories-in-feeling'* (Klein 1957). I have argued elsewhere (Turp 1997, 1998) against any automatic pathologizing of somatic self-expression and management of feelings. In everyday living, bodily and mental self-expression go hand in hand. For example, tears are undeniably 'of the body' but eloquently express emotion, which can in turn be reflected upon in words. In psychotherapy also, thinking, feeling and speaking remain linked to the body:

> By implication, psychoanalytic interpretation, like all verbal expressions, cannot escape intimate links with the body. It is inseparable from sounds that are emitted physically, and thus from intonation, volume, rhythm and other forms of primitive enactment. Such an 'active' element is not necessarily a disadvantage, for it gives transference interpretations an unconscious vitality that constitutes their communicable value. (Likierman 1993: 446)

In the case of self-harm, the soma is carrying an excessive proportion of the psychic burden and can be seen to represent a client's attempt 'to take flight from what she could neither contain nor elaborate' (McDougall 1989). More fundamentally, in my view, it expresses a split between physical and psychic functioning. We are in the presence of what Winnicott (1949) referred to as a 'duality psyche–soma' and the underlying split makes possible and supports the distortions of somatic self-expression to which we are privy. Facilitating a client's shift away from an over-dependence upon somatic self-expression is a key concern. But equally pressing is the need to address the underlying split between psyche and soma, by considering the overall quality of a person's indwelling in his or her body.

5. *Self-Harm and Self-Care*

> A subsidiary task in infant development is that of psychosomatic indwelling (leaving the intellect out for the moment). Much of the physical part of infant care – holding, handling, bathing, feeding, and so on – is designed to facilitate the baby's achievement of a psyche-soma that lives and works in harmony with itself. (Winnicott 1967: 29)

This section of the paper describes how I create space for the exploration of 'psychosomatic indwelling' in clinical work. Implicit to the material I present is the idea outlined above that physical activity is not necessarily inimical to thoughtfulness. Because illness is more fully theorized within psychoanalysis than health, accounts of the inscription of early experiences on the body have focused on the inscription of negative events and their emergence in pathological psychosomatic manifestations (McDougall 1989; Wilson & Mintz 1989). My endeavour is to understand and theorize the inscription of benign experiences of handling and holding, to offer an account of physical activities which have an underlying object-related quality and to show how exploration of these might find a place in a psychotherapeutic setting.

I am indebted to Winnicott, both for his lively interest in health as well as in illness and for his eloquent work on the physical aspects of maternal holding, to which he ascribed the separate label 'handling'. Winnicott states that handling and physical care play a particular role in the infant's gradual 'personalization':

> The ego is based on a body ego, but it is only when all goes well that the person of the baby starts to be linked with the body and the body functions, with the skin as a limiting membrane. I have used the term personalization to describe this process, because the term depersonalization seems at basis to mean a loss of firm union between ego and body, including id-drives and id-satisfactions. (Winnicott 1962: 59)

This aspect of Winnicott's work has received support from several sources. Well-known research carried out with primates (Harlow & Harlow 1962) involved the 'raising' of baby monkeys by inanimate mothers. Some monkeys had only a 'wire mother' with a bottle of milk attached, while others also had a 'terry-towelling mother' to which they clung most of the time. All of the monkeys were very disturbed as adults – those who had the benefit of the terry-towelling mother slightly less so than the 'wire mother only' babies. Brought up without responsive touch and handling, they neglected themselves, did not groom properly and were completely inadequate as parents, often abandoning their own offspring. Findings from human physiology regarding the role of touch (Field 1995) add to the evidence that responsive physical handling is one of the non-negotiable needs of the human infant.

We also know from the writing of Krystal (1978, 1988) and others that any physical handling, even if rough and insensitive, is preferable to no handling at all. Even distorted and insulting forms of handling seem to have some value in warding off the danger of psychogenic death, as described by Krystal and as witnessed by Spitz (1945) in his observations of very touch-deprived infants in institutional settings. Thus, we might see self-harm as a kind of self-attention to the need for handling in order to stay alive. Several authors (summarized in Favazza 1989a, 1989b) have noted that people who self-harm suffer from feelings of depersonalization. Testimony from women in the Bristol survey confirms that self-harm is sometimes enacted in the face of experiences of numbness and deadness:

> I used to feel like the world was going on around me but I was not part of it. I interacted with it like a robot. The real me was locked up inside but I couldn't reach it. I was sealed off and I would get really desperate to break out. (Woman A, Arnold 1995: 14)

However, the price of regaining a feeling of aliveness and reality is very high, in terms of the negative experiences, both internal and external, which follow in the wake of self-harm.

We recognize that the capacity for containment of emotions and the development of thinking relies initially upon maternal processing of experiences which the infant cannot manage alone. Likewise, it seems that capacities for physical self-soothing and self-care are not automatic but evolve within a context of responsive maternal handling. Hopkins offers compelling evidence that an infant's whole way of inhabiting its body, its muscle tone and its physical liveliness, reflects the handling it has experienced. Writing about babies whose mothers have shown an aversion to close physical contact, she observes:

> These babies have been found to be no less cuddly at birth than other babies are, but by a year they neither cuddle nor cling but are carried like a sack of potatoes. (Hopkins 1990)

Where maternal handling has been largely absent or seriously distorted, as is the case for so many clients who self-harm, quality of psychosomatic indwelling merits particular consideration within a therapeutic context. Like the babies observed by Hopkins, clients who self-harm have usually suffered from a deficit of opportunities to internalize the functions of self-care and self-holding and are likely to have a damaged sense of knowing their body from the inside. As in Geoffrey's case, traumatic experiences of physical, sexual or emotional abuse may have led to a kind of 'freezing', a cutting off from the physical self and thus from the source of sensations and emotions upon which mental functioning is built. Kelerman (1985) refers to the body as 'the somatic architecture of feelings'. If experiences of numbness and dissociation derive from a cutting off from feelings, and thus from the 'somatic architecture' in which they arise, then bodily movement and bodily touch may help to restore feelings so that they are available for exploration in the therapeutic setting.

Against this background of thinking, I have found it useful to encourage conversations in the therapeutic setting which involve the piecing together of a 'touch/handling history' and consideration of what might be done to enhance self-care. Two possibilities which have emerged in such conversations are (1) some kind of physical exercise: yoga, swimming, working out at a gym, horse-riding and playing hockey, and (2) engagement with a complementary therapy: most usually massage, but occasionally body-brushing, aromatherapy or the Alexander technique.

In 1997, I offered several accounts of ways in which clients use physical exercise to contribute to their emotional well-being. Although we need to remain vigilant for signs of obsessional and self-damaging abuse of exercise, I argued that we should also be open to the ways in which exercise can restore a sense of harmony between psyche and soma, contributing to an enhanced sense of psychosomatic indwelling. The quality of the client's engagement with the activity will emerge in the dialogue and reveal when it is being used in a narcissistic or self-punishing way and when it has an 'object-related' quality. Examples of the latter are evident when, for example, the experience of being held together by toned muscles evokes memories of being securely held in a caring adult's arms, or when rhythmic activity such as riding, running or swimming re-evokes experiences of being comforted or content.

> A client, Linda, picked her skin excessively, particularly in the bath, causing sores which formed scabs, which she then picked off. She told me that, underneath her clothes, she was a mass of sores and small bleeding wounds. She also had a never-ending succession of colds and sore throats and, although she invariably attended for her session, she was never really well. On one occasion, I expressed concern not only in regard to the self-harm she described to me but in relation to her general lack of concern and care for her health. I wondered aloud

whether she was unable to imagine ways of taking better care of herself or whether she could imagine them but not bring them into play.

Linda was initially baffled by the idea that one might respond to illness by enhancing self-care, rather than by stoicism and passive acceptance. I said, 'If you were able to imagine such a thing, what might come to mind as a way of taking better care of yourself?' Bit by bit, Linda generated the following list of options: horse-riding, doing things in less of a rush, taking a holiday in the sun and going for a course of reflexology (her feet being an area of her body which did not have sores on it). I pointed out that the things she mentioned had a common element of physical enjoyment. She might have talked about changing to a better diet or taking vitamins but she had not done so. Clearly, she had a very *good* idea of the sorts of things that might help her.

Linda brightened at the suggestion that she did know what was good for her and recalled a (very rare) happy holiday spent pony-trekking with an aunt and uncle and their children. Later, we considered what currently came between her understanding of her needs and effective action in relation to them. Gradually, Linda was able to translate some of her insights into changes in her life and the intensity and frequency of her self-harming episodes began to abate.

With regard to complementary therapies, there is a distinction to be made between those which promise excessive, sometimes magical, benefits and those which are more restrained in their claims. The benefits of massage, in particular, are well proven and form a part of post-operative care and care of premature babies in many hospitals. Massage offers a safe context for being touched. Many clients who self-harm hardly know what that is, as touch has so often been associated with danger of violence or abuse.

A client, Carole, who had been physically and sexually abused, had been cutting herself on the arms since the age of 12. In therapy, she repeatedly expressed yearnings for a loving physical relationship where her need to be held and cuddled would finally be met. Unfortunately, this hunger for touch had led her into a number of unsatisfactory and damaging sexual relationships. She had come to realize that, for the time being at least, another sexual relationship was not what she wanted or needed. I simply asked her whether she could envisage any other ways in which her need to be touched might be met. Carole came up with the idea of swimming and of Turkish baths. The caress of water was safer at this stage than the touch of a human hand, albeit the safe hand of the masseur. She then ruled out swimming because she was too embarrassed about her cuts and scars. Thus, the first alternative touch that she sought out was the light, warm touch of steam upon her skin.

Eventually she found the courage to seek out a sensitive massage therapist, and processing of the painful feelings and memories which surfaced in massage sessions became central to our work together.

In all cases, the routes to better self-care need to emerge, to be discovered by the client and to be processed in terms of their resonances and meanings in the therapeutic setting. One must be very careful not to offer direct suggestions or 'prescriptions', which are likely to encourage perception of the body as a 'not-me' object or as a part-object, with adverse effects. I prefer to refrain from encouraging discussion of physical self-care too early in the work, lest the client should mistakenly identify the task in hand as simply the replacement of one kind of action with another. This would clearly be inimical to thoughtfulness and to the necessary working through of disturbing experiences.

Concluding Comments

There is a paucity of literature relating to self-harm in a 'sub-clinical' population. Most published work focuses on self-harm in institutional settings or among clients with a psychiatric history. In addition, theoretical contributions are inadequately

balanced by testimony from people who self-harm The research undertaken by the Bristol Women's Crisis Service and supported by the Mental Health Foundation goes some way towards redressing that imbalance, and I am pleased to be able to bring it to the attention of a wider audience.

Dr Buckroyd and I are setting up a groupwork project, both as a research tool and to address the needs of students who self-harm or who suffer from eating disorders. In addition to unstructured psychodynamic work, we intend to include short sessions of structured physical activities (movement, modelling, artwork) which may serve both to evoke memories and feelings and to offer 'bridges' between actions and words, as described by Buckroyd (1994).

In continuing with this work, I would welcome responses from other practitioners on the subject of their encounters with self-harm – whether in an individual or groupwork context – in psychotherapy or counselling practice.

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Touch, enjoyment and health: In infancy.

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Touch, enjoyment and health: in infancy

Maggie Turp
University of Hertfordshire

Abstract

This is the first of two papers, each of which seeks to illuminate some interconnections between touch, enjoyment and health. This paper focuses on infant experiences of touch, while a second paper will focus on the role of touch in adult well-being. Both contributions are centrally informed by the work of renowned psychoanalyst and paediatrician D.W. Winnicott and by understandings emerging from the field of psychoanalytic infant observation.

The author suggests that there is a substantial overlap between the concept of health and that of psychosomatic 'indwelling' (Winnicott 1960, 1962a, 1962b, 1966, 1967, 1970). The role of touch in enabling and supporting a good sense of indwelling is considered in some detail. Of particular interest is the subject of maternal handling, including a mother's enjoyment of the physical care of her infant.

Keywords: touch, handling, health, psychosomatic indwelling, psychoanalysis, infant observation

Introduction

This is one of several papers (Turp 1997, 1998, 1999) which make reference to Winnicott's concept of 'the psyche indwelling in the soma' (1960a: 45). The concept of indwelling has affinities in (at least) three directions.

First, there is a connection to philosophical contemplation of the ongoing 'embodiedness' of the human subject reflected, for example, in

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the work of Heidegger (1927), Merleau-Ponty (1962) and Heaton (1967, 1988). Winnicott focuses in his writing on the quality of indwelling of a particular individual and its relationship to maternal care. This primary concern with *individual* and *developmental* aspects of embodiment distinguishes his work from more general and abstract philosophical considerations. His concept of 'indwelling' is firmly located within object relations theory. Nevertheless, his non-dualistic conception of embodied mind, his interest in health and everyday living and his enthusiasm for observation and description serve as valuable links between object relations and phenomenological approaches to the human subject.

Second, there is a line of connection to bodywork psychotherapy (cf. Keleman 1985; Eiden 1998; Boadella 1998). Winnicott writes that: 'the live body, with its limits and with an inside and an outside, is *felt by the individual* to form the core for the imaginative self' (1949a: 244). The perspective of bodywork psychotherapists is in some respects similar, although body psychotherapy practice differs substantially from psychoanalytic practice: 'Without anatomy, emotions do not exist. Feelings have a somatic architecture' (Keleman 1985: xii). The interface between bodywork psychotherapy and psychodynamic psychotherapy is largely unexplored and merits more detailed consideration than is possible here.

Third, there is the location of the concept of psychosomatic indwelling within object relations theory and associated psychoanalytic practice, as developed by Klein (1975a, 1975b), Bion (1962), by Winnicott himself and by a number of other eminent psychoanalysts. It is in this area of theory that the current paper is primarily located.

Psychoanalytic object relations theory argues that the infant is born into relationship, is in relation to another, from the very beginning and that his or her personality develops within the context and dynamics of that relationship. Klein (1975a, 1975b) emphasized the infant's instinctual inheritance, the primitive feelings of love, hate and envy which are present from the earliest days, the inevitable conflict between these incompatible feelings and their negotiation in the context of the earliest mother–infant relationship. Winnicott shared Klein's belief in the enormous importance of the first relationship but emphasized instead the infant's extreme dependency and desire for intimacy: 'Prior to sexuality as the unacceptable there was helplessness. Dependence was the first thing, before good and evil' (Phillips 1988: 7).

In relation to this extreme dependency, Winnicott focuses on the infant's non-negotiable need for 'holding', which includes both the holding of the baby in mind and empathic identification with his state of mind, and physical holding. In relation to the latter, Winnicott coined the separate term 'handling' and this is linked particularly to the establishment of 'indwelling':

> A subsidiary task in infant development is that of psychosomatic indwelling (leaving the intellect out for the moment). Much of the physical part of infant care – holding, handling, bathing, feeding, and so on – is designed to facilitate the baby's achievement of a psyche-soma that lives and works in harmony with itself.
>
> (Winnicott 1967: 29)

This, in brief, is my frame of reference for thinking about the psychosomatics of health and of everyday living. It forms the backdrop against which the subjects of touch, enjoyment and health are considered.

In this paper and its sequel, two related questions will be explored:

1 What is the relationship between touch in infancy, of the variety described by Winnicott as 'handling', and a well-established or poorly established sense of psychosomatic indwelling?
2 Where respectful/responsive touch has been lacking in infancy, what health-seeking options are open to the adult, and how can they be supported in a psychotherapy setting?

The first of these two questions is addressed in this current paper.

Methodology

Michael Rustin (1997) has described the consulting room as the equivalent of 'Pasteur's laboratory' in the field of counselling and psychotherapy research. From Freud onwards, there has been a kind of dance between thoughts arising from clinical case material and the development of theory.

Sue Reid (1997) has recently suggested that psychoanalytic infant observation studies constitute a second core methodology, to stand alongside clinical case material. The methodology involves weekly one-hour visits by an observer to a family which has volunteered to participate. Observations are recorded in everyday language and describe the immediate realities of the situation. Rather than applying theoretical categories or interpretations to the material, observers are strongly encouraged to open themselves to the situation and to record as accurately as possible what they see and what they feel. Later, in a small seminar group, observations are discussed and theoretical inferences may be made.

Reid argues that such observations have the same structured form as a psychoanalytic clinical encounter, usually a regular hour a week in a consistent setting, that the rules of engagement are equally clear and that psychoanalytic infant observations have a similar potential for the generation of new ideas.

This paper relies heavily on material from psychoanalytic infant observations. At some points, infant observation material is triangulated (Denzin 1970) with findings from quantitative studies. The evidence and arguments are set within a context of Winnicott's thinking.

Health and enjoyment

Over time, there have been a number of challenges, none of them conclusive, to the mechanistic strictures of the biomedical model. Such challenges have drawn attention to social and psychological influences upon illness and have sought to define health as more than just the absence of illness. The World Health Authority in 1946 defined health as: 'A state of complete physical, mental, and social well-being and . . . not merely the absence of disease or infirmity' (cited in Sheridan and Radmacher 1992: 6).

Winnicott's perspective on health rests upon his concept of a 'True Self', a core aspect of the individual which is never fully revealed and which is rooted in bodily experience: 'The True Self comes from the aliveness of the body tissues and the working of body-functions, including the heart's action and breathing' (Winnicott 1960b: 148). Personal authenticity and creativity have their origins in the True Self and are regarded as central characteristics of health: 'Let us say that in health a man or woman is able *to reach towards an identification with society without too great a loss of individual or personal impulse*' (Winnicott 1967: 27).

Health is a developmental as well as an adult issue. As a clinician, Winnicott was extremely concerned with the deleterious consequences for infants of mothers who were unable to provide 'good-enough' handling. Where experiences of responsive touch were lacking or disturbed, he described an 'uncertainty of indwelling' (1966) and a vulnerability to psychosomatic illness in adult life. His illustrative clinical material (e.g. 1949a, 1966) includes descriptions both of patients who experience 'depersonalization', describing themselves as 'not feeling real', and of those who suffer from extremely serious, sometimes life-threatening, psychosomatic illnesses.

Recently, Heaton (1998), citing Gadamer (1996), has explored the 'enigmatic' quality of health. Like Winnicott, he links the concept of health to positive feelings of well-being, creativity and enjoyment.

> Now health, as we indicated earlier, has a hidden character but manifests itself in a feeling of well being. It shows itself when we are open to the world and forgetful of ourselves, when we are creative. We are close to it when we enjoy ourselves and this itself represents a kind of treatment.
>
> (Heaton 1998: 40)

I am suggesting that such enjoyment is based upon the underpinning of a '*good-enough*' (Winnicott 1949a: 245) quality of psychosomatic indwelling.

According to Winnicott, a distinction is to be made between certain kinds of *pleasure*, including sexual pleasure or the satisfaction of eating when hungry, and *enjoyment*, including full sexual enjoyment or the appreciation of good food. This distinction parallels his differentiation (1971) between instinctual and ego-related pleasures. Instinctual pleasure may survive in the absence of a good quality of psychosomatic indwelling, but enjoyment must surely be compromised.

My basic contention, then, is that health, including the capacity for enjoyment, depends upon a good-enough experience of psychosomatic indwelling, with its connotations of wholeness, of feeling all of a piece within a skin, of being, as Heaton puts it, 'in touch with the vitality of living which has no end outside itself' (1998: 35).

Touch, handling and physical indwelling – Winnicott's account

Winnicott develops his account of psychosomatic indwelling on the basis of a proposed 'inherited tendency of each individual to achieve a unity of psyche and soma, and experiential identity of the spirit or psyche and the totality of physical functioning' (1966: 112). Winnicott argues that the flowering of this inherited tendency is dependent upon experiences of responsive touch or 'handling'. Such experiences are seen as a crucial aspect of maternal care, with far-reaching consequences for infant and adult health. Bion, writing at around the same time, used the term 'containment' (1962) to refer to *all the ways* in which maternal care helps an infant to encompass and process his or her experiences. Winnicott's term 'holding' covers very similar ground. However, he adds a second term, 'handling', underlining the particular significance he attributes to physical aspects of infant care, and to the accompanying frame of mind of the maternal figure.

> Part and parcel of holding is what Winnicott refers to as *handling* – the way the mother handles her infant in all the day-to-day details of maternal care. Here is included a mother's *enjoyment* of her baby, which is an expression of her love.
>
> (Abram 1996: 187)

Winnicott's emphasis on the helplessness and dependency of the infant underpinned an understanding of the infant as 'all the time *on the brink of unthinkable anxiety*'. He writes that:

> Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what the baby needs in the general management of the body, and therefore of the person.
>
> (Winnicott 1962b: 57)

It is in the nature of such primitive anxieties that they cannot be thought about or understood but can only be experienced in a physical way. Winnicott refers to them as 'the stuff of psychotic anxieties' and lists them as 'going to pieces', 'falling for ever', 'having no relationship to the body' and 'having no orientation' (Winnicott 1962b: 58). The physical reassurance provided by good handling is vital in keeping such anxieties at bay.

In a number of papers, Winnicott links handling specifically to the process of 'personalization'. Abram summarizes this work in the following way:

> Good-enough handling results in the infant's 'psyche indwelling in the soma'; Winnicott refers to this as 'personalisation'. This means that the infant comes to feel, as a consequence of loving handling, that his body is himself or/and that his sense of self is centred in the body.
>
> (Abram 1996: 187)

When unthinkable anxiety is not kept at bay by sensitive and responsive handling, the infant may split off a 'caretaker' part of himself in a desperate and psychologically costly attempt to meet his own emotional needs. Such splitting may manifest itself in the precocious development of mental functioning, which constitutes '*an encumbrance to the psyche-soma*, or to the individual's continuity of being which constitutes the self' (Winnicott 1949a: 248). As Winnicott develops his account, he suggests that this splitting off of mental functioning may be countered by the appearance of psychosomatic illness (1966). Such illness is regarded as both expressing the damage and forcibly bringing the physical self back into the picture, through its expression of a tendency 'not to altogether lose the psycho-somatic linkage' (1966: 515).

Winnicott makes it clear that touch, in the simple sense of physical contact, qualifies as good-enough handling only when it is contingent upon and responsive to the needs of a particular infant at a particular time. Subsequent research by Trevarthen (1979) and Stern (1977) emphasizes the importance of timing and reciprocity in the physical and vocal 'dance' of maternal and infant communications. Commenting on the relationship between this work and Winnicott's perspective, Lynne Murray writes:

These researchers have described the engagement as having a conversation-like form, and their observations have confirmed the empathy and identification that Winnicott described as stemming from the mother's 'Primary Preoccupation' with her baby with demonstrations of fine, unconscious, adjustment to infant sensitivities.

(Murray 1989: 338)

One function of 'primary preoccupation' is to allow the infant, in the very early stages of life, to maintain an illusion of omnipotence, to feel that, when he is hungry and the breast appears, he has in fact *created* the breast. When his mother comes and picks him up, he ideally feels that he has brought about this welcome event. In health, early physical care supports rather than impinges upon the illusion of omnipotence. The infant is not aware of external care, as such, but simply of a continuity of going-on-being within his own body.

Such a state of affairs must depend upon a very close attunement of mother to infant. Such attunement is congruent with care that is *enjoyed* rather than with care which is dutifully discharged:

> The baby does not want to be given the correct food at the correct time so much as to be fed by someone who loves feeding her own baby. The baby takes for granted all the things like the softness of the clothes and having the bath water at just the right temperature. What cannot be taken for granted is the mother's pleasure that goes with the clothing and bathing of her own baby. If you are there enjoying it all, it is like the sun coming out for the baby. The mother's pleasure has to be there or else the whole procedure is dead, useless, and mechanical.
>
> (Winnicott 1949b: 27)

At a later stage, the infant becomes more able to recognize the mother as separate, with needs and wishes of her own and not entirely under the infant's control. The infant's chosen 'transitional object' (Winnicott 1953) assists in this process. With the help of this object, which is both 'me' and 'not-me' and which can substitute to some extent for the maternal figure, the infant is able to soothe and comfort himself, to increase his tolerance of impingements from the environment and to fall asleep when he needs to. The most frequently selected transitional objects – an old teddy bear, a piece of cloth or blanket or a furry animal toy – have markedly tactile qualities, which make them particularly suitable for clinging onto, stroking and cuddling. However, these comforts cannot be made use of by the infant in the earliest months of life and,

even later, can only complement rather than substitute for maternal handling, supported by maternal enjoyment of handling.

Corroborating evidence

Evidence in support of Winnicott's account comes from a variety of different sources, including the work of developmental psychologists referred to above. Here, I draw upon psychoanalytic studies, human physiology research and infant observations. Some studies explore the positive role of touch and handling, while some focus on the consequences of distortions or deficits in touch and handling.

In 1945, Spitz reported on the sad and shocking consequences of touch deprivation for hospitalized infants in the USA, some of whom died, apparently from psychogenic causes. Partly because of the publication of his findings, conditions improved. The institutions he had visited changed or were disbanded and thus ceased to exist as 'natural laboratories' for the study of touch deprivation. For obvious ethical reasons, further research was carried out with primates rather than with human subjects (e.g. Harlow and Harlow 1962), and this has produced further evidence of negative effects on health of touch deprivation.

Research has also been carried out in the realm of human physiology. Results again suggest that human touch is crucially important to an infant from the very earliest moments of life. For example, several studies, summarized by Tiffany Field (1995), describe the progress of premature babies who receive 'kangaroo care', spending their early days in almost continuous skin-to-skin ventral contact with the mother (by living inside her T-shirt). These babies show less fluctuation in body temperature, heart rate and respiration rate and better weight gain, and are ready for discharge from hospital significantly earlier than control group babies. The adoption of 'kangaroo care' also has emotional consequences. 'With kangaroo care, more mothers breast-feed, and mothers feel more fulfilled about their pregnancy. The parents become deeply attached to their infants, and they feel confident about caring for them, even at home' (Field 1995: 40). Significant results have also emerged from research into the consequences of including premature babies in a programme of baby massage (Barnard and Brazelton 1990; Field 1995). The benefits enjoyed by babies receiving massage echo those described above in relation to 'kangaroo care'. There were measurable benefits across a whole range of physiological indices and, in addition, infants receiving massage seemed more contented and easier to soothe.

In the light of the above research, I find it surprising that no hospital accommodation is normally made available for the mother of a premature baby. Largely through the efforts of psychoanalyst James Robertson

(1953) it has become accepted that an older child or baby benefits from his mother's continuous presence in hospital and may suffer greatly from a long separation. And yet these very tiny and immature babies must manage with very little maternal touch and soothing. Every technological effort is made in relation to their health, but the evidence that they fare better when they experience as much maternal handling as is practicable has not translated into widespread changes in hospital practice. Perhaps, because these babies may not survive, there is an unconscious denial of their full humanity and of their normal infant need for a full quota of responsive touch and handling.

The quantitative evidence from the field of human physiology complements psychoanalytic descriptions, which offer more of a sense of what it might be like to enjoy the everyday experiences of responsive touch or to be in a touch-deprived state. Hopkins has described infants born to mothers who showed an aversion to physical contact. 'These babies have been found to be no less cuddly at birth than other babies are, but by a year they neither cuddle nor cling but are carried like a sack of potatoes' (Hopkins 1990). The deprivation encountered by Hopkins in her study is less extreme than that witnessed by Spitz (1945) and the babies do not die, but one does have a sense of them becoming a 'dead weight'. Hopkins' work suggests that an infant's whole way of inhabiting its body, or quality of physical indwelling, is an eloquent reflection of the handling it has experienced. Experiences of responsive touch, or of its absence, become visibly inscribed upon the body. The implication is we are unable to hold ourselves well if we have not been well enough held, and that this will be reflected in muscle tone and posture. Emotional and physical aspects of such a state are simply two sides of the same coin, with the collapsed and sagging posture, described by both Hopkins and by Bick (1968), encapsulating feelings of hopelessness, of passivity and of depression.

Psychoanalytic infant observation

Psychoanalytic infant observation offers the opportunity to consider quality of physical indwelling and its relationship to the evolving relationship between mother and infant in more detail. The mother of an infant I observed, whom I shall call Emma, seemed quite depressed during Emma's first year, as the following extracts show. As an observer, it was not my place to enquire into her state of psychological health. However, this mother later confided to me her sense of relief that she was feeling more 'back to her normal self'. During the first year of the observation, she often put Emma down when Emma would clearly have preferred to be held. Caught in a rather withdrawn and self-absorbed state, the mother seemed unable to respond to Emma's need for more contact.

Extract from observation of 'Emma', age 9 weeks

Emma's eyes close and she seems to be dozing at the breast, just giving the occasional suck. Almost immediately, Mother takes her nipple out of Emma's mouth and moves Emma away from her breast. Emma lies in her lap and waves her arms towards Mother's face, whilst looking at her intently. She makes tiny sounds and tries to turn and lean in to her mother's body. Mother looks away from her and starts to talk to me. Emma then starts to wriggle and make grumbling sounds, that soon turn into a low grizzle.

Mother turns back to her and says 'Are you going to be awful today? You're a hungry girl today, aren't you, you monster?' She says to me 'I feel awful today. I haven't felt so awful in a long time. I've taken some Paracetamol, but I've still got a headache'. In a lower tone, she confides, 'Actually, breast-feeding makes me feel awful, kind of weird, nauseous and drained'. Turning to Emma, she says 'You're sucking the life out of me. That's what it is!' Emma stops crying when Mother speaks to her but is making odd contorted faces. Her mouth is fixed in a tense crooked line and her eyes are screwed up. Mother says, 'Would you like to go in your chair?'. She puts Emma in her rocker chair near me. Emma does not protest but is inert and uncooperative. Mother finds it difficult to insert her floppy legs behind the straps of the rocker chair and Emma slumps immediately to one side. Mother disappears into the kitchen and I hear her starting to make coffee, then talking on the telephone. After a couple of minutes, Emma again starts crying in a low-key grizzly way. She is collapsed in the chair with a sideways list. Her chin sinks on to her chest and she does not look up or make eye contact with me.

At this stage, Emma is invariably put down as soon as a feed is finished and is held very little. For the most part, she is left in a rocker chair and her mother often leaves the room to make long telephone calls. Emma's appearance seems to illustrate the slumped and resigned bodymind state, which Hopkins (1990) describes and which is one of the possibilities included in Bick's (1968) account of the development of a 'second skin'. Rather than a toughened 'second skin' to hold the infant together, albeit at the expense of permeability and a possibility of relationship, Emma seems to express a weakened sense of skin, barely any skin at all. Instead of manic activity and overdeveloped physicality, I witness a sagging posture, half-hearted crying, and a lack of physical vigour as a response to inadequate holding and handling. Emma's physical state seems to mimic the mother's sense of a sagging and depleted breast, which she feels to have been 'sucked dry' by her infant.

In the following extract, Emma is being looked after with her twin cousins, who are a few months older. Her mother and her aunt are both in the room.

Extract from observation of 'Emma' at 6 months

Twin B has pulled Twin A's dummy out of his mouth and is proceeding to try to remove his left ear from his head, producing howls of rage and protest. Aunt is on the phone, but is forced to hang up and rush to the twins. She separates the boys and puts them in high chairs at the table in the kitchen end of the room. Emma is in her rocker chair, at the other end of the room. At first, she moves her head and eyes to follow events and her face is animated. She calls to her mother, who is looking in a mirror and fixing her make-up, but receives no response. After a minute, she lowers her gaze and ceases to make sounds.

The scene is noisy and chaotic, the Twins now shouting out in their high chairs and banging their bottles on the table. Mother joins Aunt at the table and chats about her driving lesson, while Aunt prepares food and feeds the twins. Emma seems quite forgotten and is not brought up to the table.

Emma grabs the bottom of her red T-shirt, screws it up with both hands, lifts it and pushes it into her mouth, where she sucks it for a while, producing a large wet patch. As she lets it drop from her mouth, I see that her face has fallen and her chin now rests down upon her chest. Her body is starting to lean sideways and sag in the chair and her eyes are downcast. Her mouth is slightly open and drooping at the corners. I feel terribly for her sadness and isolation. Checking my watch, I see that is now 15 minutes since anybody interacted with Emma. I find it very difficult not to reach out and touch her.

This mother is not physically neglecting her baby, who is well fed, regularly changed and cleanly clothed. When Emma has her nappy changed, or is fed or bathed, she does, of course, receive some touch and handling. However, feeding often coincides with chatting on the telephone; nappy changing takes place in front of the television, mother often focusing on the TV screen rather than on Emma; bathing is a rather brusque and practical procedure. For the most part, there is no attempt to play with Emma or to develop the kind of early 'conversation' described by Trevarthen (1979). Winnicott's description of such handling as 'dead, mechanical and useless' is perhaps an exaggeration. As Spitz's work has shown, babies who are not cared for physically, even

to this extent, suffer far more harmful consequences. However, it is by no means the same thing as handling which is enlivened by maternal enjoyment.

Compared to other babies being observed, Emma at this stage lacks a definite 'personality', seeming flat, unanimated and apathetic. She does not express the liveliness and curiosity which are evident in other infants of a similar age. Often she seems to be retreating into herself, holding on only to the low monotone of her crying. Physically, she is pale and often suffers from colds. Her movements have a restricted feel and lack vigour and she often looks a little hunched.

In the observation seminar, we reflect on my physical longing to reach out to Emma, take her from her high chair, change her soggy T-shirt, wipe her nose and hold and carry her for more than a few passing moments. This, of course, I am not free to do within the methodological discipline of psychoanalytic infant observation. Instead, I find myself 'having privileged access and exposure to the child's experience while being prohibited from intervention that might alter or ameliorate it' (Bridge and Miles 1996). Along with several other colleagues in the group, I recognize similar physically experienced longings in relation to some adult clients, many of whom eventually recount a history of difficult or missing experiences of touch.

Reid (1997) presents extracts from the observation of an infant 'Freddy', whose experiences of handling seem considerably more disturbed than Emma's. Very early on, Freddy is handed to the observer, who notes that 'He is a calm baby who quickly moulds himself into the shape of my body' (Reid 1997: 552). However, this benign state of affairs is not to last. Freddy is fed from the start 'on the edge of the mother's knees, back towards her, with the bottle held out in front of him, so that he could not see his mother at all' (Reid 1997: 551). The observer feels uncomfortable. Freddy is not securely held, but might easily fall off the edge of the mother's lap. Throughout the feed, his mother chats to a visitor, so that Freddy is dropped from mind, as well as in danger of being dropped physically. Later events are felt by the observer to go beyond a failure of containment (Bion 1962) and to be actively cruel:

> From 20 days onward the observer, with increasing frequency observed Freddy lying on the dining-room table on a cloth. Mother was usually holding Frances (age 18 months), or otherwise engaged. The observer noted that even at 10 days old Freddy struggled to roll himself up on the table and, when this failed, he tried to stick himself to the little blanket and turned his head from side to side with his mouth open until he found his hand and sucked on it for a long time. This seemed to keep him calm for some time before

eventually he burst into tears, quickly becoming congested. Mother told him he was bad and Frances then smacked the baby, which amused mother. The observer reported that she had the greatest difficulty in not picking the baby up in her arms.

(Reid 1997: 552)

By three and a half months, Freddy's posture seems visibly to reflect these experiences. His top half is described as 'hard and stiff', while his bottom half seems very floppy:

> Perhaps the stiff top of Freddy's body illustrated his attempt by the use of his musculature to hold himself together and to protect himself against attack, whilst the floppy bottom half might be seen to represent his abandonment, his unheld state.
>
> (Reid 1997: 553)

These observation extracts offer week-to-week accounts of the inscription of early handling experiences upon the posture and physical appearance of a child. In both cases, the observer experiences a strongly felt physical inclination to 'rescue' the infant and to attend to its unmet needs for loving and responsive handling. I will return to this latter subject in a second paper, when considering 'embodied countertransference' (Field 1989) responses to certain adult clients.

I have previously drawn attention to a psychoanalytic tendency to focus excessively on pathologies, on sickness and disturbance, and to give relatively little attention to recovery and health. Finding myself in danger of replicating this same imbalance, I shall return to the consideration of recovery and health.

Towards the end of her first year of life, substantial changes occurred within and around Emma. First, her mother's depression began to lift. However, her capacity to enjoy being a mother was still somewhat marred by a fear, which she confided to me, that her depression had damaged her daughter. Meanwhile, Emma began to crawl and then to walk. These developments, in themselves, seemed to militate against a sense of passivity, helplessness and abandonment. Emma was no longer entirely dependent upon her mother's responsiveness to her cues. She could act more decisively and effectively on her own account. Her growing capacities seemed also to reassure her mother that no lasting damage had been done. Emma's physical approaches to her offered reassurance that she was still loved. In Kleinian terms (1946, 1957), Emma had preserved her mother as a good object, in spite of the difficulties in their relationship. Her new-found mobility made it easier for her to show her love:

Extract from observation of 'Emma' at 13 months

Mother and Emma are in the living room. Emma is crawling around the room, while Mother sits on the large and well-padded sofa, reading the newspaper.

Emma's first stop is at a picnic hamper, lying with its lid open on the floor. With difficulty, she climbs inside it, wriggling and curling herself to sit in the confined space. When she is settled, she looks over at Mother with great self-satisfaction, pursing her lips and making happy talking sounds. Mother laughs. 'You are funny', she says. Immediately, Emma climbs out of the basket, crawls over to Mother and pulls herself into an upright position, using Mother's leg for support.

Emma tries to climb up – it is quite high. After several attempts, she gets a knee up onto the cushion and manages to lever herself up, then pulls herself into standing position next to Mother, this time using the back of the sofa to help her. Mother is still trying to read the newspaper. Emma chats to her 'Uh-uh. Yeah-yeah', then throws herself front down over Mother's knee, scrunching the newspaper and giggling. Mother puts her arms around Emma and laughs. 'You'll fall off the sofa!' she says jokingly. She sets the crumpled newspaper aside. Smiling and happy, Emma crawls around the sofa and around Mother's lap, burying her head in the soft cushions and then in Mother's skirt and croaking softly. She pulls herself up and again flings herself face down over Mother's knees in delightful abandonment, relying on Mother not to let her fall off. Mother cuddles her and tickles her, saying 'You'll fall, you'll fall!' but not really sounding at all worried. Emma again crawls all around the sofa, head down, butting, snuggling and snuffling like a little animal on all fours. Then she again pulls herself up using the back of the sofa and throws herself onto Mother. This sequence of Emma standing momentarily, then throwing herself down, is repeated many times. Each time is becomes a little more daring and abandoned. The game is accompanied by high-pitched squeaks of excited laughter. Eventually Emma approaches the edge of the sofa and looks over.

'Go *off* backwards', warns Mother, and helps her down.

As well as illustrating the enjoyment of touch by both mother and infant, this extract draws attention to a more general relationship between the modalities of *movement* and *touch*. We know that all the modalities operate in a co-ordinated way from very early in life (Stern 1985; Trevarthen 1989). Against this background of cross-modal operation, touch and movement seem to have a particular affinity with one another.

Physiologically, movement excites the skin receptors, which also respond to pressure and warmth, as well as proprioceptive receptors deep in the muscular-skeletal structure of the body. Because of muscular involvement and the operation of the sense of proprioception, which informs us of the position and speed of movement of our various body parts, movement has a quality of 'inner touching'. Emma seems greatly to enjoy her new found mobility and it may be that crawling and walking, in themselves, help to compensate for her earlier paucity of touch experiences. Perhaps more importantly, mobility enables her to elicit from her mother experiences of touch and handling which had been lacking in earlier months. Now, crawling and climbing and being cuddled and tickled merge together in her and her mother's mutual enjoyment.

Winnicott also seemed to recognize a close relationship between the modalities of movement and touch/handling:

> When we provide a swimming pool and all that goes with it, this provision links with the care with which the mother bathes her infant, and with which she generally caters for the infant's need for bodily movement and expression, and for muscle and skin experiences that give satisfaction.
>
> (Winnicott 1962a: 69)

The changes described seem to have contributed to a 'virtuous circle', where Emma's evident physical and emotional survival both reassure and delight her mother, who is now able fully to enjoy her daughter. Emma's physical appearance is transformed and seems to carry the imprint of these changes. Where she was pale, she is rosy-cheeked. Where her facial expression was flat and unanimated, it has become expressive and ever-changing. Where she was quiet and withdrawn, she is cheeky and outgoing or sometimes noisily angry and upset. Her nose stops running.

Another month later, at 14 months, she manages to walk under her own steam. Soon, she is marching up and down the room, wearing a cheeky and confident expression, and looking, as we might say, 'a picture of health'.

73 Torbay Road
London NW6 7DU
MaggieTurp@aol.com

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5.

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Working with body storylines.

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Working with body storylines

MAGGIE TURP

ABSTRACT The author considers the appearance in a therapeutic setting of a 'body storyline', involving a client account of using or experiencing the body in a particular way. For example, a client may describe taking up a physical activity such as running or seeking out a 'hands on' therapy such as massage.

While such activities *may* stand in opposition to thoughtfulness and symbolization, the author argues against any tendency automatically to regard them as psychologically unhelpful. Such activities also have the potential to support the operation of thoughtfulness and symbolization, contributing to a coming together of action, thinking and feeling. Where they operate in this way, the author suggests that they play an important role in supporting psychosomatic health.

A case study is included, to illustrate how the beneficial potential of body storylines can be brought into play within a psychodynamic setting.

KEYWORDS Psychodynamic, psychosomatic, health, recovery, physicality, narrative

INTRODUCTION

The narratives referred to here as 'body storylines' have both a history and a present reality. They stretch back far into the past, encompassing experiences of touch and movement from infancy onwards. They encompass the pleasures and difficulties issuing from fundamental physical experiences, such as eating and sexual

self-expression. Several different kinds of evidence, including infant observations, clinical work and quantitative studies, combine to suggest that such experiences become inscribed upon the body. Once embodied, they are expressed in posture and physical style, in our avoidance of or enthusiasm for different physical experiences, in the terms we select when speaking about our embodied selves, in the physical responses we evoke in others and in a variety of other ways.

A desire to understand the meanings of different somatic manifestations has informed psychodynamic theory from the beginning (Freud and Breuer 1893) and has continued through the work of McDougall (1974, 1989) Wilson and Mintz (1989) and many others. Most of this work has had a strong focus on psychosomatic pathologies. As Charles Rycroft put it:

> Psychoanalysis began as a branch of medicine and its raw material still derives from people who are in trouble and seeking help; it has therefore more to say about illness than about health, and a tendency to describe human nature in a terminology derived from pathology.
>
> (Rycroft 1991: 17)

My own concern, here and elsewhere (1997, 1998, 1999a, 1999b), is to begin to develop a complementary body of work to illustrate and illuminate how different uses of physicality may contribute to psychosomatic health. The term 'psychosomatic health', as I use it here, is strongly linked to Winnicott's concept of psychosomatic indwelling (Winnicott 1960, 1962, 1966, 1967, 1970), summarized by Abram in the following way:

> Good-enough handling results in the infant's 'psyche indwelling in the soma'; Winnicott refers to this as 'personalisation'. This means that the infant comes to feel, as a consequence of loving handling, that his body is himself or/and that his sense of self is centred in the body.
>
> (Abram 1996: 187)

I believe that some uses of physicality act primarily in the interests of safeguarding or restoring of a good quality of psychosomatic indwelling. In the absence of any recognition of beneficial uses of physicality, one end of the psychosomatic continuum will tend to remain under-theorized and under-recognized. We will be vulnerable to confusing the cessation of psychosomatic symptoms with psychosomatic health, or the absence of episodes of self-injury with self-care. We may also find it difficult to distinguish between defensive or

damaging uses of physical activities and those uses which are psychologically beneficial.

A number of colleagues have written to me to comment on previous publications. Many interesting points have been raised and I have been asked for additional practical descriptions of counselling work which draws on the perspective I have described. This paper is, in part, a response to such requests. It begins with a general exposition of a certain way of thinking and of working and continues with a longer clinical example.

METHODOLOGY

Qualitative research methodologies are commanding increasing respect. Michael Rustin has recently argued anew the merits of the clinical case study, which has been at the heart of the psychoanalytic endeavour from the very start. He refers to this methodology as the 'psychoanalytic equivalent of Pasteur's laboratory' (Rustin 1997).

While each story is individual and particular, pattern and meaning emerge over time and certain themes are repeated, both within the narrative of an individual client and between the narratives of a number of clients.

This paper utilizes primarily the research method of the clinical case study.

THERAPEUTIC STYLE

The work I have in mind when I refer to 'working with body storylines' falls within the normal parameters of a psychodynamic approach. The ordinary, careful elucidation of possible meanings of a particular communication proceeds with reference, where appropriate, to issues in the transference and with close attention to counter-transference feelings and intuitions.

Beyond this, I pay particularly close attention to three sources of information. The first source is any change in my own posture and physical style. I believe that we often unconsciously echo the posture of another person, particularly where we wish to understand a little more of their experience of the world. Our own physical way of being in the presence of a particular client is therefore a useful source of information. By being physically aware of ourselves, we can understand more about the client's quality of psychosomatic indwelling. Linked to these postural identifications are our

'embodied countertransference experiences' (Field 1989). These experiences are discussed later, under the heading 'Disturbances of psychosomatic indwelling', and are a second important source of information. Thirdly, I listen out for verbal references to experiences and activities which are characterized by their physicality, for example, eating, running or going for a massage. (When referring to such experiences and activities as a group, I shall describe them as 'emphatically physical', meaning that it is their physical aspects that make them what they are.) I keep such references in mind, find a way of letting the client know that I am interested in them and select them for further elaboration when the right moment comes along. In the case study below, I try to give a picture of how this looks in practice.

Some comparisons with other ways of working with bodily issues may be helpful, although I accept that my understanding of approaches I do not use must be somewhat limited. A bodywork therapist may work with movement or massage within the counselling session to evoke memories and feelings held in the body. Difficulties with erotic transference issues and a preference for leaving the therapeutic space open and unstructured are among the reasons for the avoidance of physical contact in psychodynamic counselling and psychotherapy.

My own procedure is to invite verbal exploration of bodily experiences taking place *outside* the psychotherapy session, whether in the recent or the distant past. My position is similar to that expounded by Jungian psychotherapist, Joan Blackmer Dexter:

> But the real body work, the consistent, laborious process of differentiating and awakening the body, needs in my experience to be done separately, outside of the consulting room.
>
> In the physical training arena one learns by doing. In the analytic hour one tries to discover what the doing means psychologically and symbolically.
>
> (Blackmer Dexter 1989:112)

An important principle in my work is to follow the lead of the client. I have seen a Gestalt practitioner make direct reference to a bodily gesture, which the client has not intended to be seen. For example, seeing a clenched fist, the Gestalt therapist may ask the client: 'What does your fist want to do?' While I would also regard a clenched fist as significant, I would not comment upon it unless invited to do so by a suitable cue in the client narrative. Direct comments about another person's body or bodily state are often experienced as intrusive and

disrespectful (socially as well as in the counselling setting). A psychodynamic concern would be the possibility of unconsciously re-enacting the piercing attentions of a real intrusive mother.

As psychodynamic practitioners, we strive to maintain an 'evenly suspended attention' (Freud 1912) while also understanding that we bring certain belief systems and sensitivities into the consulting room. Inevitably, these have a role in influencing which aspects of client discourse are chosen for elaboration. As I see it, the body has a rightful place in the expression and management of feelings, which is complementary to the role of thinking and verbalization. A satisfactory experience of living can surely be based only in a feeling of being embodied. Winnicott writes that: 'the live body, with its limits, and with an inside and an outside, is *felt by the individual* to form the core for the imaginative self' (1949: 244). Later, he links this theme to his concepts of true and false self: 'The True Self comes from the aliveness of the body tissues and the working of body-functions, including the heart's action and breathing' (Winnicott 1960: 148).

Because I consider these matters to be of particular significance, I am probably particularly sensitive to any loss of harmony between physical and mental aspects of the self and to endeavours to restore such harmony, to regain or retain a 'good enough' quality of psychosomatic indwelling.

VARIETIES OF PSYCHOSOMATIC PROCESS

Most practitioners are familiar with and have given some thought to phenomena described by McDougall (1974) as *'mysterious flights'*, either from *body to mind* or from *mind to body.* The former is exemplified by the client who experiences the body as numbed and dissociated and has a feeling of 'living inside the head'. She characteristically employs a 'reporting' style of (non)engagement. Her account is intellectually coherent but seems based on a previously prepared text. The latter applies to the 'classic' psychosomatic scenario, where emotions and the words to express them have gone missing and the whole burden of self-expression falls upon the body. In either event, we are likely to hear about a range of psychosomatic symptoms or related body/mind disturbances such as losing a sense of being embodied (dissociation), self-injury or eating disorders.

Because the literature focuses primarily on psychosomatic processes active in illnesses and disorders, we may be less attuned to an inner

push towards reintegration of physical and mental aspects of the self. In his work on psychosomatic indwelling, Winnicott advanced the view (contrary to the dualistic assumptions of his era) that *in health* the psyche-soma functions as a unity. Psychological and physical aspects of a person form a seamless continuity. If we agree with this perspective, then we have a basis for understanding that 'mysterious flights' (in either direction) become possible *only when the underlying unity of the psyche-soma has already been compromised.* A tendency towards a recovery of psychosomatic unity is held in some kind of tension with defensive processes of splitting and numbing (Winnicott 1966). In clinical work, a tendency towards reintegration may become more apparent as counselling progresses, both signalling and contributing to the client's recovery.

As well as communicating distress to the outside world in a number of ways, a symptom causes a sufferer to remain aware of her 'embodiment'. Symptoms, self-harm or eating disorders insist that the body is kept in mind and thus militate against the most drastic form of psychosomatic disturbance, namely a total split between physical and mental aspects of the self.

> In this way the psychosomatic illness implies a split in the individual's personality, with a weakness of linkage between psyche and soma, or a split organised in the mind in defence against generalised persecution from the repudiated world. There remains in the individual ill person, however, a tendency *not* altogether to lose the psychosomatic linkage.
>
> Here then is the *positive value of somatic involvement.*
>
> (Winnicott 1966: 113)

The psychosomatic pathology carries within it the unconscious hope of re-unification of psychic and somatic aspects of the self, of recovering a sense of being all of one piece within the skin. Over time, and with the help of a sensitive counsellor or psychotherapist, this tendency can become explicit and begin to find more effective expression.

Clearly, this range of concerns is broader than that traditionally included within the subject area of psychosomatics. A client who has been feeling very low arrives ten minutes late and tells me: 'I almost didn't come today. It was so very difficult to get out of bed', and then there is a long pause. Even as simple a communication as this presents many options, not all of which can be followed up. The counsellor may be inclined to speak of the client's evident reluctance to come and refer back to a difficult preceding session, or to a recent occasion when she herself was absent. Another possibility is to pick

up on the body storyline. 'You found it really difficult to get out of bed....' If I say this, I register to the client an interest in the quality of that experience and implicitly invite her to say more. At the back of my mind will be questions about what 'bed' might signify for this client, how she experiences herself physically as she struggles to rise, what history and resonance getting out of bed may have for her. Experience tells me that following this line of enquiry means that the client, if just once she feels energetic and springs out of her bed, will tell me so. More than once, such a very physically felt shift has been recognized by counsellor and client alike as the first sign of change, a precursor to a fuller recovery which is still some distance away. Where a client is struggling to hold on to hope, recognition and acknowledgement of such moments can be very significant.

INDICATIONS FOR EXPLORING A BODY STORYLINE

White and Epson (1990) have described a narrative as always containing an 'excess of data'. Inevitably we must select some client storylines for elaboration and let others slip by. Selecting a body storyline is often an option but I have found it a particularly appropriate choice in the two following circumstances:

1 where there are distinct signs of disturbance in the client's quality of psychosomatic indwelling, and
2 where there are distinct signs of an attempt to repair a schism between physical and mental facets of the self.

I describe these two circumstances in greater detail below. It will be seen that they form a continuum, with a substantial area of overlap between them.

In order to build effectively upon Winnicott's insights, we need to recognize two possibilities implicit in emphatically physical activities. On the one hand, such activities may be inimical to and stand in opposition to the operation of thoughtfulness and symbolization. On the other hand, they may support and be complementary to the operation of thoughtfulness and symbolization, involving a coming together of action, thinking and feeling. Sometimes, both tendencies can be seen in operation in the same client at different times. It is always vital to consider a particular individual's quality of engagement with a particular activity at a particular time.

DISTURBANCES OF PSYCHOSOMATIC INDWELLING

As is clear from psychoanalytic literature, psychosomatic symptoms and related syndromes, such as eating disorders or self-injury, form a part, often a stubbornly rooted part, of a pathology and can be problematic to manage and profoundly resistant to change. However, like all defensive processes, these symptoms and related pathologies have their functional aspects. Several writers (e.g. McDougall 1989; Collins 1996) have vividly described ways in which they can communicate underlying conflict and distress. When the client is poorly equipped to put words to her emotional disturbance, she is likely unconsciously to communicate her true state of neglect, abandonment or desperation through the pattern of primitive communication so eloquently explored by Klein and post-Kleinian analysts under the heading of projective identification (Klein 1946).

Being on the receiving end of projective identifications, the counsellor may first become aware of the client's disturbance via his or her body countertransference experiences. I have at times experienced a strong urge to hold a client physically, or repeatedly seen a client as much younger than she is. I have found myself involved in fantasies of providing a healthy and hearty meal or a set of warm and comfortable clothes or of releasing a client's scraped-back hair from its pony-tail and seeing it swing free. Such body countertransference responses are both complex and revealing. While reflecting on the unconscious bodily communications, the psychodynamic counsellor waits for the client to indicate in her narrative that she is ready to explore the underlying issues verbally. This is one of two linked ways of 'listening with the body' (Field 1989). It stands alongside the process of paying attention to echoes of the client's state of indwelling in one's own posture and style through close attention to the somatic countertransference.

Sooner or later, a client will probably communicate a disturbance of psychosomatic indwelling in a verbal way as well. She will refer to ways in which she compromises her health through too little sleep and relaxation, excessive consumption of alcohol or coffee or a very poor diet. She will apologize for her unkempt appearance. She will let you know how dissociated from her body she feels, by referring to her bodily self as a 'not me' item, as an object viewed from the outside. In this case, the body may be cared for in a cosmetic and mechanical way, but there is no sense of indwelling or inhabitation. Where there is this objectification of the body, one must also be alert

to the possibility of self-injury or excessive risk-taking or serious self-neglect. As a client's quality of psychosomatic indwelling improves, the counsellor may become aware of this through changes in his or her body countertransference experiences as well as through changes in the quality of verbal communications.

PSYCHOSOMATIC 'BIDS FOR HEALTH'

Although one cannot speak of recovery without also alluding to illness, I have given recovery processes a special focus in this work on account of a current emphasis on pathology, in psychodynamic literature. The paucity of case studies and associated theoretical developments concerning psychosomatic health and recovery has practical consequences. It is possible that unconscious endeavours to repair a split between psychic and somatic aspects of the self will be overlooked or even misinterpreted in counselling and psychotherapy practice.

For example, a client may describe engaging with an emphatically physical activity or seeking out an emphatically physical experience. Common activities include jogging, swimming, enrolling in a gym or a dance class, taking up a sport or going on a walking holiday. Or the experience may be more oriented to the modality of touch, involving massage or related therapies. Recently, I worked with a client for whom the physicality of gardening was extremely important. Practices incorporating a particular emphasis on breathing, such as yoga or singing, may also feature. Because of the emphasis in the literature on pathological uses of physicality, such activities may be automatically interpreted as flights from thinking. A possible function of seeking to restore a good quality of psychosomatic indwelling may be unrecognized. Indicators of beneficial rather than pathological uses of physical activities include thoughtful client descriptions of what it feels like to engage in them and connections to a range of memories, feelings and associations.

In between pathological and beneficial uses of physicality lies a mixed area involving the compensatory or 'neutral' use of illness or physical exercise or physical ritual. For example, it is not unusual for a film to include a scene where the protagonist slugs it out on a squash court with a friend, after suffering a severe (if usually temporary!) disappointment or loss. There is some denial implicit in this vigorous activity, but the feelings are nevertheless being managed in a non-destructive way. This can be seen as a kind of holding operation, which

takes on a pathological colouring only if it becomes entrenched and the underlying issues remain unaddressed.

In distinguishing between beneficial and pathological uses of physical activities and 'hands-on' therapies, it is important to consider the client's style of engagement with the activity. To what degree is the body experienced as inhabited and to what degree is it objectified? Sometimes the situation is finely balanced and verbal exploration of the activities involved can play a decisive role in determining their use or abuse. Where body storylines are thoroughly explored and their meaning emerges clearly, there is the possibility of supporting and building on their beneficial potential. The primary importance of working psychodynamically with body storylines lies in this potential for transformation.

CLINICAL CASE STUDY

I would like to share a case which concerns issues of 'false self' and of 'feeling real' (Winnicott 1949, 1960) and illustrates how a body storyline can provide a thread through the client material.

A female client aged 42, whom I shall call Betty, came to see me as a private client. During our first meeting, she struggled for words to describe what was troubling her, repeating several times 'I just don't know'. She said 'I could be anybody. I have no idea what I am like'. I asked whether these were new thoughts and sensations. Betty said that, on the contrary, *they went back as far as she could remember.*

As well as having a full time job in a bank, Betty was a single parent of two boys, aged 14 and 12. Although the boys saw their father for holidays, Betty looked after them most of the time. She described a very busy life, saying 'I do things the whole time. I'm always busy getting things done. I'm like a machine, really'. I echoed the words 'You're like a machine' and noticed as I said it that Betty *looked* rather machine like. She sat very square and upright in the chair. Although she was quite animated, her movements were fast, short and clipped rather than long and expansive. At the same time, I noticed that I was sitting square and upright myself and taking less time than usual to simply be with the client. My breathing was shallow and I felt under an internal pressure to respond quickly.

I asked Betty if she could say more about being like a machine, which led to her saying that she drove herself like a car and just got on with things on automatic, in response to the many practical demands made upon her. I asked her if that meant that she took very little time to think about herself, to consider how she felt. She agreed that this was the case and I said that some things could only be known by consulting within oneself. The fact that she didn't take

time for this might well be connected to her idea that 'she could be anybody'.

Later, an occasion arose when I pointed out to Betty that she had created *a bubble of space for herself* in choosing to come for counselling and that, in view of what she had said, this seemed significant and something of an exception to her usual way of being. Now we both fell into more of a reverie. Betty said slowly 'A bubble of space... Yes, that *isn't* like me' and looked slightly tearful. Then she quickly pulled herself together and apologized, saying that she had been a bit down these last few weeks. I felt very moved by Betty, catching glimpses of real despair, buried beneath a competent and reliable persona and a warm social manner. We worked together for three years in all and some fragments of our work are described here.

Quite early on, Betty (who looks neither over- nor underweight) tells me she has been on a number of diets in order to lose weight. As we discuss this issue, her account turns out to be something of an understatement. In fact, Betty is *always* on a diet. We establish that she never chooses a meal on the basis of what she feels like eating. Instead, she vets its calorific and fat content, tots up her scores for the day and then decides what she is allowed to eat. She describes these activities as 'on automatic' and 'a kind of constant background noise' and tells me in a despondent tone that they have been going on 'for years and years'. I am struck by Betty's depressed tone of voice and think that she may feel, in some way, very neglected, because she makes so many decisions without any regard to her own enjoyment. When I say something along these lines, Betty makes a connection to our earlier discussion about machines. One does not consult a machine about its needs, as all machines are more or less the same. The machine is simply supplied with what it *ought* to need. I ask Betty if she can imagine what it would be like to live more fully within her body, to consult her appetite and her preferences and to act accordingly. Betty slumps a little, looks worn down and stares at the floor. She says sadly 'Why would I do that?'

By this time, Betty has given me an outline description of her family. She has described her father as an evasive man. 'He often worked late or buried himself in a book. He didn't seem very interested in us girls.' She has also told me that her mother was rather strict and domineering. In this session, she goes on to say with considerable feeling, 'I was so afraid of my mother. Later I hated her, but I never let her know. In all these years, I've never asked her to look after the boys. She doesn't understand how to love a child.' My comment 'She didn't know how to love you?' brings a snort of derision. 'That was the last thing on her mind. She just wanted to make sure that we didn't step out of line. As long as we did what she said and made a good impression, that was all that mattered.' There is a long pause and Betty struggles not to cry. Eventually, I say that, under such circumstances, I can see that there is not a lot of point in consulting within oneself. To follow one's own feelings would be likely only to lead to trouble.

It seems to me that Betty probably started to cut off from her somatic self, her 'true self' which Winnicott cites as the source of spontaneous feelings, during her childhood years. Her body is experienced as cut off, dead and mechanical. In addition, Betty now carries within her a very critical and prohibitive voice, which derives primarily from her experiences as a girl. This combination of affairs makes it very difficult for her to be spontaneous, which would involve being in touch with something that feels real and comes from inside. Betty's obsessive pattern in relation to food seems to be one aspect of this scenario.

> Betty returns to the subject of her diets, saying that she wants to make a change, thinking it might help her to find her 'real self'. But whenever she comes to the point of actually giving up her counting and vetting, she becomes quite terrified. When I ask her what she thinks might happen, Betty becomes breathless and hugely anxious. 'I don't know. *Anything* might happen. Anything at all.'
>
> We reflect that counting and restricting have become old friends, as well as old enemies. Betty admits that she would 'feel altogether unsafe' without them. I notice that I am also feeling anxious and that my own breathing has become somewhat constricted. I say to Betty that there seems to be something in the present situation which relates to not feeling safe. She says 'I had to be careful. My first concern was not to upset my mother. Often she lost her temper about the smallest thing, like me not remembering where I had put my gloves. I don't think I ever *just did something*. First I would try to judge what mood she was in and whether it would make her angry, which meant I would get slapped and shouted at and then she would sulk for days – not look at me or speak to me. The atmosphere in the house – I can't describe it. Tension you could cut with a knife. Everyone leaning on me to "apologise to mother" so that things could get back to normal. . . . You could hardly breathe.' This revealing communication opens up an opportunity to consider how Betty might be trying to please me and how fearful she might be of my imagined disapproval. We also log the fact that Betty almost ceases to breathe when she is anxious and that this makes her feel more dissociated from herself and less 'real'.
>
> In spite of the progress made, Betty remains unable to stop counting calories. She tells me she feels more and more frustrated with being hemmed and hedged in by her self-imposed restrictions. At one session, she announces that she has decided to start a daily run. I ask her how that decision has come about and she tells me: 'Running will keep me in trim. If I can believe that, if I can let that be enough, then maybe I can ease up on the diets.' I say: 'It sounds as though you hope running will wean you off the diets. I shall be interested to know how you get on.' The next week, Betty tells me

that she has started a daily jog, described as 'a boring grind to and from the local park'. I suggest that the counselling process has allowed her to feel that change may be possible, that she may be able to move away from a style of self-restriction that has been going on for years. At this point running seems to me to fall into the 'compensatory' category of psychosomatic processes, with one self-enforced and mechanical activity being exchanged for another. In contrast to this rational evaluation, I feel very interested in Betty's running. An image comes to mind of her puffing and panting and I remember her words that she was 'hardly able to breathe' at home. However, somewhat to my chagrin, Betty makes no further mention of running in the sessions for several months.

During this time, I notice that Betty is beginning to look different. I have a sense of more flowing movements and of more vitality, a sense of energy without strain. One day, she tells me about a particularly enjoyable weekend with her two sons, that ended up with them eating at Burger King on Sunday. I say that things must have changed a bit on the diet front if she is now able to go to Burger King. Betty says 'Well, now I'm running so much, I have different attitude to food. I have to make sure that I eat enough good things.' I express pleasure at this hard-won change and go on to say that, as far as I can remember, she has now been going running for four or five months. I add that I remember it was quite tedious at the start.

Betty laughs and says 'I'd forgotten saying that. Oh no, it's not a bore at all now. I just love it.' We think about this and Betty realizes that, almost imperceptibly, the feeling and meaning of running has completely changed for her. 'I started it to control my weight but now I do it *just for me*. I have so much more energy, actually. My problems haven't gone away but somehow they don't get me down in the same way. I go every morning that I can and I just feel so different.' I am struck by the phrase '*just for me*' and say what a big change that seems for Betty. There is a long silence, then Betty begins to speak with enormous regret of all the years she has spent living for others, never able to just be herself, always 'putting on a show'. This ushers in a series of painful sessions, where Betty allows herself to know how humiliated and belittled she felt when she was growing up, and how fundamentally those experiences have affected her enjoyment of life as an adult.

A few months later, Betty returns again to the subject of running. She says she has started running with a group of other women and wants to tell me what good fun it is. We spend some time thinking about this new development. Now running is not only '*just for me*' but also stands as a metaphor for taking up a larger space in the outside world. Betty and her friends enjoy a sense of being a substantial presence in the park. I notice again that Betty looks very different from when I first met her – taller, more confident, more relaxed. On another occasion, Betty tells me she is thinking of starting to train for the London Marathon. She has made contact with a charity which

is interested in sponsoring two women from her group. 'My parents won't even speak about it. They are totally disapproving. My sons tease me but they let me know they are really proud.' The recognition that her sons love her and do not find her wanting is still sufficiently new to Betty to bring tears to her eyes.

By this time, I would say that Betty has attained a 'good enough' quality of psychosomatic indwelling and that this process has been helped by running and by exploring the successive meanings of running in a psychodynamic setting. The measure of these changes is in Betty's range of emotion, in her more solid sense of identity, in her attitude to diet and exercise, in her relaxed appearance, in her more open posture and in her lively interest in both the world outside and her inner world.

I offer this account as an example of working in a psychodynamic style with a body storyline. I believe that running, which could so easily have been another obsessive and mechanical activity for Betty, has in the event been transformational, not least as a result of our consideration of its meanings and associations in the therapeutic setting.

CONCLUSIONS

One might speculate that this era in Western civilization provides a perfect context for a poor quality of psychosomatic indwelling. Except in the very highest echelons of society, our grandparents' generation were engaged in physical work every day. I am not thinking here just of male industrial or farm workers; even doing the washing or making a cake involved quite a lot of physical effort before machines arrived to make it so quick and easy. While this way of life was hard, resulting for some in premature death from exhaustion and overwork, it did have the advantage of supporting an ongoing sense of psychosomatic indwelling. The body was always being used, often quite vigorously, and it is likely that a sense of identity with the bodily self was sustained by such use.

Manual labour has long been associated with low status. Now there is a reduced necessity for physical work and fewer and fewer people choose it. In addition, we are in the midst of a cultural emphasis upon appearances, the surfaces of things, particularly of our bodies. Whether it is to be perfected, sculpted, deprived, obsessed over, injured, ignored and neglected, complained about or narcissistically

worshipped, the body tends to be regarded as 'other than', outside the self. More attention is lavished on its appearance than on its use.

The conceptual situation is somewhat complicated: clearly the body is both 'indiscreet' and an object existing in external space. But when objectification is a dominant cultural theme and a sense of indwelling correspondingly fragile, we may anticipate that certain kinds of problems are likely to be experienced with increasing frequency.

For individuals who have a poor history of physical experiences, at worst involving neglect or physical or sexual abuse, the prevailing cultural mood is likely to add to their difficulties in feeling properly 'embodied'. Too often, their whole perception of the body is as if from the outside looking in.

Perhaps as a counterweight to the cultural tendencies described above, an increasing number of people take up a sport or a vigorous physical activity such as running or a meditative physical activity such as yoga or tai chi. Many more seek out some kind of 'hands-on' complementary therapy. These tendencies are also reflected in the lifestyles of the clients who come to us. Through close attention to their body storylines, we can make explicit the ways in which such activities either come into the service of a pathological (and often narcissistic) objectification of the bodily self or contribute to a good quality of psychosomatic indwelling. By this means, we may also support shifts in activity, or shifts in the use of an activity, which enhance its beneficial potential.

I hope I have succeeded in demonstrating that this is by no means a separate counselling activity. It is an integral part of the process of overall change.

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Maggie Turp, Counsellor and Supervisor in Private Practice; Researcher/Lecturer, The University of Hertfordshire, 73 Torbay Road, NW6 7DU, E-mail: MaggieTurp@aol.com

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Touch, enjoyment and health: in adult life

Maggie Turp

University of Hertfordshire

Abstract

This is the second of two linked papers. Like the first, it offers a perspective on interconnections between touch, enjoyment and health, on this occasion in adult life rather than in infancy. The theoretical underpinning for the work resides in Winnicott's account of the establishment, resilience and susceptibility to damage of a sense of 'the psyche indwelling in the soma' (Winnicott 1960a: 45).

Drawing on case study material, the author considers some of the ways in which touch deprivation in adult life might find expression and illustrates how such deprivation might be worked with verbally in the psychotherapy setting.

Keywords: touch, handling, health, psychosomatic indwelling, psychoanalytic psychotherapy, Winnicott

> Now health is enigmatic. Illness is something we know quite a lot about whereas health is more mysterious.
>
> (Heaton 1998: 38)

Heaton is not the only writer to have noted the difficulty in pinning down the meaning of the term 'health'. I shall confine myself here to a brief description of how I use the term, acknowledging that mine is by no means the only usage in circulation. I refer to a number of linked tendencies, rather than to a fixed state. These tendencies include the establishment or recovery of 'a psyche-soma that lives and works in harmony with itself' (Winnicott 1967: 29) and of relationships which allow for authentic self-expression, while at the same time playing sufficiently by the (socially constructed) rules of interaction. To quote from Winnicott again: 'Let us say

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that in health a man or a woman is able to reach towards an identification with society without too great a loss of individual or personal impulse' (Winnicott 1966: 112).

Winnicott refers to 'indwelling' on many occasions (1960a, 1962a, 1962b, 1966, 1967, 1970), although it is not one of the concepts to have been chosen for development by others who have elaborated on his work. In the first of these two papers (Turp 1999b), I described the aspect of Winnicott's work which concerns the establishment in infancy of a good quality of indwelling, which Winnicott regards as absolutely dependent upon good-enough experiences of maternal handling. I presented extracts from my observation of a moderately touch-deprived infant, who suffered from a 'feeble establishment of indwelling' (Winnicott 1966: 515) and became particularly prone to psychosomatic illnesses. I also referred to evidence from primate studies (Harlow and Harlow 1962) and from earlier psychoanalytic studies (e.g. Spitz 1945) attesting to the very damaging and sometimes fatal consequences of severe touch deprivation.

'Handling', 'indwelling' and adult health

To what extent do the infant needs outlined by Winnicott continue to hold sway in adult life? Do we continue to depend upon responsive touch experiences in order to *maintain* a good enough sense of indwelling/embodiment? Can a sense of indwelling weaken or become lost in adult life? As therapists working with people who find themselves in trouble and who come to us for help, we may also have in mind a more specific question: 'Where respectful/responsive touch has been lacking in infancy, what health-seeking options are open to the adult, and how can they be supported in a psychotherapy setting?' (Turp 1999b: 25).

Winnicott's writings do not specifically address these questions and this paper involves an extension as well as a re-presentation of his ideas. However, there are some general indications to work from. We know that Winnicott was more drawn to the Kleinian idea of 'positions' – to be revisited and grappled with many times during the course of a lifetime – than to the Freudian idea of 'stages', which could, in theory, be successfully completed and left behind for good. Klein (1946) had emphasized that the paranoid-schizoid position, where bad feelings are split off from good feelings in order to ensure the survival of the latter, would be returned to again and again at times of crisis. Winnicott indicated that a different kind of split – an unnatural split between psyche and soma – was a recurrent risk in adult life. In 1962, he wrote that 'Certain tendencies in personality growth are characterized by the fact that they can be discerned from the very beginning, *and they never reach completion*' (italics added). Among such 'tendencies in personality growth', Winnicott included 'What might

be called "in-dwelling": the achievement of a close and easy relationship between the psyche and the body, and body functioning' (Winnicott 1962a: 69).

These comments suggest that Winnicott believed there were ongoing possibilities for gains (and by implication for losses) in quality of physical indwelling throughout adult life. And, since he linked quality of indwelling so closely to handling experiences in infancy, it seems reasonable to suppose that he would have considered handling and/or self-handling experiences to be psychologically significant in adult life.

Touch and touch equivalents

Touch and movement: physiological overlaps

It has been argued that all of the sense modalities operate in a co-ordinated way from very early in life (Stern 1985; Trevarthen 1979). Against this background of cross-modal operation, touch and movement seem to have a particular affinity with each other.

Some aspects of this affinity are based in physiological overlaps. For example, movement causes stretching of the skin, which excites some of the same skin receptors that respond to the pressure and warmth associated with tactile stimulation. The involvement of proprioception (the sense which informs us of the position and speed of movement of our various body parts) in both touch and movement experiences may also endow movement with a quality of 'inner touching'.

Touch and movement: psychological overlaps

Movement and touch co-occur experientially from the start of life. A newborn baby is gathered up, rocked and cuddled. Movement and tactile contact join together in the one experience. From very early on, a healthy infant plays an active part through his or her movements in the experience of being handled. Recently, I observed a baby of eight weeks being carried in the crook of his mother's right arm. As she leaned over, bending down to pick up some toys from the floor, he adjusted his posture so that he remained curved into and parallel to her body.

I had observed this baby participating in his handling since he was born, for example by moulding into his mother's body when she picked him up. By the age of eight weeks, he had expanded his repertoire. When all goes well, as in the example above, infants are *active* in being held and carried. And in ordinary 'good-enough' circumstances, the demands made upon them by the mother are finely, though unconsciously, matched to the infant's developing capacities for postural adjustment.

For older children, mobility is centrally involved in the expression of attachment behaviour. A child may use his mobility to distance himself from a parent or parent substitute, so long as he still feels that the parent is available as 'a secure base' (Bowlby 1988). Such an exploration will typically conclude with the child crawling or running to the parent and stretching up his arms to be picked up. Echoes of this pattern can be observed in adult life. A woman is meeting a close friend from a train. Seeing her climb out, she runs along the platform, stretches out her arms and an embrace follows. Through repeated associations, certain kinds of movement may evoke 'memories in feeling' (Klein 1957: 180) of being greeted, comforted or rejected. Walking or running may call to mind experiences of being held and handled that have accompanied or followed them. This 'object-related' aspect of movement experiences, which is seldom referred to, can offer a valuable perspective when working with client narratives of physicality.

Symbolic equivalents of touch

> The rationale that touch inhibits the process of symbolising implies that the body is related to the concrete literal level and the mind to the symbolic level only – an outdated dualistic concept.
>
> (Eiden 1998: 2)

On this point, although their practice differs so substantially, bodywork therapists like Eiden and psychoanalytic therapists may find themselves broadly in agreement. As we grow older, the close association between movement and touch is joined by other associations, as experiences that are *symbolically* equivalent to touch take on an importance of their own.

For example, I might say that I feel 'stung' by a person's harsh words or that a criticism is a real 'slap in the face'. And might I not feel my cheek burning, as if I had indeed been physically struck? There is a fine line between illusion and delusion, and sometimes this 'as if' quality of symbolic touching may be lost. One client showed clearly that his therapist's words felt like physical touch. At times, he would peel and brush the therapist's words off his jacket and flick them away as if he could not bear to have them impinge upon him (C. Klich, personal communication 23 June 1999).

Gaze can also count as touch and has the potential to help a person to feel in contact with a source of support and containment. A talk comes to mind, given by the child psychotherapist Dilys Daws in 1999 for the Squiggle Foundation.[1] Referring to her psychotherapeutic work in a baby clinic, Daws described positioning herself for part of the time near the baby weighing scales. Here, she was able to observe how a mother might 'wrap the baby around with her gaze and her voice' while the baby was being

weighed, and how this helped the baby to hold himself together through the weighing procedure.

Later in life, gaze also has the capacity to offer a kind of virtual 'handling' that supports the completion of a nerve-wracking task. A child in a school play may falter in the middle of his lines, but turning to the audience and seeing the love and support in his father's gaze, he feels able to continue. If physical proximity were possible, the father might touch the child's shoulder, an action which would fulfil the same supportive function.

Attachment theory offers a useful conceptual framework for considering these matters. The gaze of a parent or other attachment figure signals his or her availability and helps to keep a child's anxiety levels within manageable limits. A 'secure base' (Ainsworth 1969; Bowlby 1988) for demanding explorations and endeavours is felt to be in place.

Touching and not touching in psychotherapy

Readers will be aware of the longstanding debate about touching or not touching in psychotherapy, which concerns both the ethical status and the efficacy of 'hands-on' work within the psychotherapy setting. I think it is fair to say that, over time, positions have tended to become polarized around rather fixed points of view. A useful review of the lines of argument can be found in Kertay and Reviere (1993).

Typically, those who oppose hands-on work in psychotherapy argue that bodywork therapists are either missing the point or risking working unethically, or both. On the other hand, bodywork psychotherapists argue that verbal psychotherapy fails to 'work with the body' or 'work with the whole person'.

There are two separate issues to be considered: the issue of informal physical contact – for example, shaking hands when a client comes into the room – and the question of structured physical contact, in the form of a massage or a bioenergetics exercise. As far as informal physical contact is concerned, I follow the conventional psychoanalytic practice of keeping such contact to a minimum. However, in common with many colleagues, I do question the validity of a total 'touch taboo'. For example, I would consider it unhelpful and potentially wounding to refuse to respond to a client-initiated handshake.

How helpful is it, though, to offer support or reassurance through informal physical contact, even if such contact would fall well within the boundaries of ethical practice? Casement (1982) describes his client 'Mrs B's' request that he allow her to hold his hand, as she struggles with the memory of a traumatic childhood event. This event involved the young Mrs B. being operated on under local anaesthetic, during which procedure her mother fainted. Mrs B. remembered feeling terrified as her mother's hand slipped

away and she disappeared. Casement is at first inclined to agree to the request, but in the end refuses it, despite intense pressure from the client. His rationale is that, in order to work through the trauma, the client needs to re-experience the defining element of the original situation which involved *not* having her hand held.

Moving on to the consideration of *formal* bodywork interventions, we might ask: how possible is it really to integrate bodywork and verbal approaches within the one therapy setting? Two clients recently came for psychotherapy, both having previously attended sessions with bodywork psychotherapists. The first told me that she had decided to leave her previous therapist because there was no 'psychotherapy' element, by which she meant there was no verbal exploration of the physical experiences she underwent. The second complained to a colleague that the previous therapy was 'just talking', that there was no 'hands-on' work at all, and that she found this confusing because it was not what she had expected (Dr J. Buckroyd, personal communication 4 February 2000).

Quite apart from the difficulties implied by these accounts, I think there is a rather strong case for keeping physical exercises and structures in their own space, quite separate from the psychotherapy encounter. First, the risk of serious misunderstandings between client and therapist is somewhat reduced. Second, it is clear that only a certain level of intimacy can be tolerated and sustained in any particular situation. Beyond this, the experience is one of intrusion and abuse. The avoidance of tactile contact in psychotherapy increases the potential for other kinds of intimacy, for example within the transference–countertransference matrix (Ogden 1997) and the play of unconscious communication.

Working with the 'whole person'

I endeavour, never with complete success, to avoid using the words 'mind' and 'body'. Like Winnicott, I reject the dualistic notions inherent in these terms. However, alternative 'holistic' terms are in short supply and some of them are unduly esoteric. It seems that Winnicott wrestled with the same linguistic dilemma. Although he insisted that, in health, the psyche-soma is a unity, he also conceded that 'We are quite used to seeing the two words mental and physical opposed and would not quarrel with their being opposed in daily conversation' (Winnicott 1949).

Whatever terms we select, it seems to me that we all necessarily work with the reality of embodiment, in the same way that we all work with the reality of the cultural embeddedness of the client's narrative and of the psychotherapeutic discourse itself. The client enters the room as an embodied human being. We are ourselves embodied human beings. We are continuously informed about a client's state of being through his or her

posture, stance, calmness or fidgetiness, through the vitality or limpness of his or her movements and in a thousand other physically expressed ways. In addition, by tuning in to our own bodily states, we become consciously aware of unconscious to unconscious communications as they emerge in the somatic aspects of the transference-countertransference matrix.

Somatic aspects of the countertransference

In practice, somatic aspects of the countertransference are entwined with the thoughts and images that drift into the therapist's mind as the client speaks or remains silent. I became particularly aware of this on one occasion when I was working with a young woman whose fine blond hair was scraped back tightly into a ponytail. So unforgiving was the pressure on her hair that I could see the roots pulling at the skin around her hairline. Sitting in my chair, I experienced simultaneously a feeling of misery and frustration, a fantasy of her hair falling free as the rubber band constricting it was removed, a physical urge to cross the room and remove the band and a fleeting image of myself doing exactly that.

I am not the first psychotherapist to have noted that there is usually a rationale for such strong physical reactions and images, a rationale which may not yet be evident in what is being communicated in words. In Roy Schafer's terms (1992) the therapist is responding to a 'showing', which is not yet a 'telling'. Psychological difficulties are finding a somatic form, which in turn evokes a powerful response in a sensitive onlooker. This is particularly likely to happen in a psychoanalytically informed setting, where the play of unconscious to unconscious of communication is at the centre of the proceedings.

At some level, it seems that the client wants the therapist to know what she unconsciously knows herself – the 'unthought known' (Bollas 1987) of trauma, abuse, neglect, rejection or other pain. The channel of communication in play is that of projective identification (Klein 1946), a process elaborated by Bion (1962) in his consideration of pre-verbal communications in infancy. Through projective identification, the client unconsciously informs the therapist about her inner world by stirring up in the therapist similar feelings to her own. Such feelings may be related to present circumstances, or they may have been experienced in the past but denied access to consciousness.

Naturally, such phenomena have implications for practice. I have come to recognize in myself certain countertransference responses to clients who, in one way or another, look dishevelled, ill nourished or physically ill at ease. I know that I may find myself feeling sad and hungry, even though lunchtime is some way off. At other times, I may feel so low that I can hardly find the energy to speak.

Nathan Field states that:

> Some states of fear, rage, longing and hunger may date back to a time when no words were available and psychic trauma could not be distinguished from physical injury. In these cases bodily symptoms in the therapist may provide the first clue to understanding. Thereafter the patient may begin to gain insight into their experience.
>
> (Field 1989: 514)

An embodied countertransference response must be counted as extremely valuable if, as Field suggests, it can offer a way of knowing something of the quality of a client's very early experience. By reflecting on his or her somatic countertransference responses, the therapist echoes the maternal function of joining up the physiological and psychological, referred to by Winnicott:

> The beginning of that part of the baby's development which I am calling personalization, or which can be described as an indwelling of the psyche in the soma, is to be found in the mother's ability to join up her emotional involvement, which is originally physical and physiological.
>
> (Winnicott 1970: 264)

When psychotherapy proceeds well, the client has the opportunity to internalize the therapist who is able to undertake this 'joining up' and subsequently to find his or her own way of fruitfully linking symptoms, physical sensations and actions to memories, thoughts and feelings.

Touch deprivation in adult life

Touch deprivation in the present: elderly citizens

As we move into late adulthood, our 'tactile' circumstances change. We are less likely to have young children to attend to. We are less likely than previously to be in a sexual relationship. If we lose a longstanding and affectionate partner, we lose the touch experiences that were a part of that relationship and they are not easy to replace. Activities involving vigorous movement, which, because of the overlaps between touch and movement, might to some degree substitute for touch experience, are also likely to diminish. And if we experience a narrowing of our social world, then touch equivalents such as gaze and holding in mind will also be less available to compensate for deficits of physical touching.

In my previous paper, I outlined the evidence that baby massage results in significant emotional and physiological gains for babies included in a massage programme, whether premature or full-term. There is also evidence

that the benefits described extend to the adults involved in the programmes. Depressed mothers seemed to benefit from *giving* massage. In a kind of 'virtuous circle', they perceive their infants as being easier to soothe, and improvements in the mother's mood and the mother–infant relationship follow (Field 1995: 110).

In one particular study, grandparent volunteers undertook the baby massage. These grandparents both received massages and were trained to give massages to neglected and abused infants. In an unlooked-for finding, the grandparents themselves reported less anxiety, fewer depression symptoms and significantly improved mood (Field 1995: 112).

The possibility of widespread touch deprivation among the elderly seems to be beginning to receive slightly more consideration than formerly. A project has begun where volunteers take pets on regular visits to homes for the elderly, to be patted and stroked by the residents. Hairdressing has always been popular in hospices and residential homes and offers an important and non-intrusive experience of 'handling'. There is also an increasing availability of 'hands-on' therapies, such as massage and aromatherapy, in some hospices and these services are well-used and much appreciated by the patients (I. Bremner, St. Christopher's Hospice, personal communication 5 June 1999).

To judge from the anecdotal evidence available, the role of touch deprivation in depression in various sub-sections of the population warrants considerably more research than has been undertaken to date.

Touch deprivation in the past: clients showing psychosomatic disturbance

Many clients who express their distress through psychosomatic illness or physical self-harm describe a very poor history of touch. Maternal handling may have been lacking or it may have been punitive or erratic. 'Normal' handling may have misfired because it was not contingent on the child's need but was dictated by the mother's needs. One client recounted being scooped up for a cuddle by her mother when she was absorbed in a game with a friend. As a result, the client felt angry and embarrassed.

Clients who injure themselves often have a particularly poor history of touch experiences, with a high incidence of emotional coldness, physical abuse and sexual abuse. Depersonalization, involving a split between psyche and soma aspects of the self, may be among the consequences. Several authors (summarized in Favazza 1989a, 1989b) have noted that people who injure themselves frequently report feelings of depersonalization and dissociation. Such considerations have led me to suggest that 'we might see self-harm as a kind of self-attention to the need for handling in order to stay alive' (Turp 1999a: 317).

This suggestion is in line with Winnicott's thinking on the meaning of psychosomatic pathologies (among which I include various forms of self-harm, such as eating disorders and self-injury). On many occasions, Winnicott drew attention to the health-seeking nature of such symptoms, in as much as they oppose the continuation of a defensive split between psychological and physical aspects of the self:

> [P]sycho-somatic illness implies a split in the individual's personality, with weakness of linkage between psyche and soma, or a split organized in the mind in defence against generalized persecution from the repudiated world. There remains in the individual ill person, however, a tendency *not* altogether to lose the psycho-somatic linkage.
>
> Here, then, is the *positive value of somatic involvement*.
>
> (Winnicott 1966: 113)

When sufficient attention is given to the 'body storyline' (Turp 1999c) which forms a part of the narrative, clients manifesting psychosomatic disturbance may be able to use the psychotherapy setting to identify less damaging ways of countering the threat of dislocation and depersonalization. A number of my clients have found a way to engage creatively with touch and movement needs outside the psychotherapy setting. Their choices of activity have included swimming, steam baths, aromatherapy, horse-riding and Tai Chi. I have understood these external changes to be based on the gradual internalization of a therapist who is able to hold in mind a client with physical as well as emotional needs, and to feel concerned that these needs should be met in a non-destructive way.

'Gentle bumps': a case study of Richard

A client, whom I shall call 'Richard', came to see me at the age of 28, suffering from painful feelings of isolation. He described himself as depressed and beset by feelings of hopelessness. Richard attributed his difficulties to shyness and to a lack of confidence in social situations. He told me that these difficulties meant that he had very few friends and also that he had very little sexual experience.

A few sessions into our work together, Richard began to speak, with considerable embarrassment, about his behaviour in London Underground stations. He told me very hesitantly that on every journey, he engineered a number of 'gentle bumps', small collisions with other passengers. These incidents took place in the corridors and hallways which he traversed, when changing trains on his journey to and from work.

I said that I could see it was difficult for him to speak about these matters, but that I thought they were important and that I would like to know more. Richard told me that his strategy was almost to avoid the person coming

towards him, then at the last moment to make a very slight adjustment of direction and posture so that the physical contact was made. It was important to him that the collision passed more or less unacknowledged. A 'successful' bump caused no pain to either party, and was not sufficiently significant to warrant an apology. Richard tried to manage six to ten such bumps on each journey. I asked Richard what he made of the situation he was describing, but he could only shrug his shoulders and look down at his hands.

My first thought was that these 'bumps' spoke of suppressed feelings of aggression. I thought of Melanie Klein's very young client, who 'bumped' figures of horses together in a simulation of sexual intercourse between his parents. However, it struck me as I mulled the matter over that something about the quality of the incidents described and of Richard's presence in the room suggested other possibilities. I found myself feeling sad, strangely exposed and uncomfortable. I noticed that I had folded my arms over my chest. I said to Richard: 'There is something rather poignant about what you have told me. I don't know at the moment what we should make of it. We shall have to wait and see what sense it makes.'

Over time, a number of thoughts and memories surfaced and a clearer picture began to emerge. Richard was the only child of parents who 'were not much given to hugging and kissing'. He lived alone and had done so since leaving his family and coming to London to work. Now he told me that whole days went by when he touched no-one. The 'bumps' were his only form of human-to-human contact. I experienced in Richard's plaintive tone of voice and in his posture an unconscious plea for me to hold him physically, which could not yet be put into words.

Six months into the therapy, Richard began to describe periods of dissociation and depersonalization. At these times, he experienced himself as 'blank' and 'empty' and was tormented by images of himself as a disembodied 'talking head'. On one occasion, he arrived in an extremely agitated state. Two days earlier, he had happened to see an old 'Monty Python' television programme. The introductory sequence included a 'man' who was just a large and bizarre head spouting forth words. Then a foot came down and crushed the head. This image terrified Richard and re-appeared in nightmares on the two following nights. On both occasions, Richard woke up in a panic, remembering only this image and the feeling that he had no body and was about to disappear.

At this point, I felt that Richard was in a very fragile state and I urged him strongly to increase the frequency of his sessions to twice a week. This suggestion led to the emergence of very negative feelings towards me. Richard questioned the whole point of therapy, saying that I did not really feel anything for him. I was just earning my living. I acknowledged Richard's anger and his feeling that I was just going through the motions.

Later in the session, I was able to suggest to Richard that the root of the issue might be that, like his mother, I denied him cuddles and kisses and all of the physical affection that a child might rightfully expect from the people close to him. Richard cried when I said this and looked at me longingly. I said that his resentment at this situation was perhaps linked to his denigration of other aspects of our relationship. He had decided that I felt cold towards him and uninterested in him. These interpretations seemed to bring Richard some relief. His face relaxed and he looked at me in a more friendly, hopeful and trusting way. When he arrived for his next session, he told me that he would like to begin coming twice a week.

Although progress had been made, this was by no means the end of the issue. It gradually became clear that Richard's resentment towards his mother and towards me was echoed in a refusal to give other possibilities for meeting his touch needs any chance of success. On one occasion Richard began a sexual relationship but managed to sabotage it almost before it had begun by always getting up and going home immediately after intercourse. The encounter lasted only three weeks.

At around this time, I noticed that I had begun to feel uncomfortable and to fidget in my chair when I was with Richard. I could not seem to find a position that felt right (even though this would not be a problem with the following client). Richard always sat at one end, the end nearest to me, of the sofa that doubles in my consulting room for a couch. In a characteristic pose, he set himself squarely on the sofa and placed his hands, palms up, on his knees. Feeling that my discomfort in the countertransference must have a meaning, I turned my attention to the physical elements of the situation.

As he spoke, Richard began to gesture with his hands and he thrust his head forward. His head and hands seemed very large and lively. At the same time, the rest of his body was in retreat from me. Thin and unanimated, pressed against the back of the sofa, it seemed to recede from view. It occurred to me that Richard was not at all sure how close he wanted me to be. He seemed at the same time to reach towards me and to hang back. The next thought that came to mind was that this was the same mixed message that he had given to his girlfriend, when he moved towards her in sexual intimacy but then retreated from her as soon as possible.

I shared these thoughts with Richard, apparently prematurely, as he made no response at all. However, he returned to the matter in the next session and began to talk openly about an enormous need for touch and comfort, a 'touch hunger' which he felt could never be met. His need and desire for love and touch were held in a fine balance with a terror of exposing his neediness and vulnerability. Richard went on to make his own links to his terror of the Monty Python image. He said he felt so cut off from his body that he feared that he was just a 'talking head'. He felt physically hollow and empty.

At around this time, new memories from early childhood began to come to mind. Richard remembered his mother telling him: 'Little boys must be brave'. I asked Richard if he thought I also expected him to be tough and brave. Looking very tearful, he was able to acknowledge that he did feel cared for by me, and that it was beginning to feel safe to own up to this sad and needy part of him.

In spite of these developments, Richard's 'bumping' activities continued unabated. Matters came to a head when he misjudged his moves and crashed into a female passenger much more forcefully than he had (at least consciously) intended. She became very angry and asked him what the hell he thought he was doing. I told Richard that I thought he wanted me to know how desperate he still felt and reminded him of the things he had told me about his 'touch hunger'. Richard said, 'I suppose I do bump into people just not to feel so alone. It's pathetic really, but at least it's some kind of contact.'

I said to Richard that he had described to me only two kinds of attempts to meet his needs for touch, the 'bumping' on the tube and the rather ill-judged sexual encounter. I wondered aloud why he seemed unable to consider other, less fraught, ways of meeting his legitimate need for touch. A couple of weeks later, Richard told me, rather grumpily I thought, that he was going to begin to go to Tai Chi classes. A male friend at work was already attending and he had decided to give it a go. As we talked this over, it became clear that the decision was related to the comment I had made. I said, 'Perhaps it felt as if I was telling you, go and sort out your needs for yourself'. Richard smiled ruefully. 'Still', he said. 'I might as well give it a go.'

In fact, Richard enjoyed the classes rather more than he had expected to. He sometimes spoke in therapy about the movements involved, and particularly about the exercises undertaken jointly with a partner. At the same time, it was clear that he sabotaged the Tai Chi project in a number of ways. He arrived home in the evening to discover that he had 'forgotten' the class. He arrived late into work on the day of the class so that he was not able to leave in time to make the class. I told Richard that I thought he was expressing his resentment towards me for apparently sending him out into the world.

Richard responded by saying that it was, of course, his mother who had sent him out into the world without the resources he needed. I said, 'You both do and don't want to recover. At one level, you would rather continue to suffer, so that you don't have to let go of your resentment towards your mother and towards me.'

After a long pause, Richard said slowly and reluctantly: 'But what if I do recover? What if I am OK? Does that mean that my horrible childhood was OK? It was so empty, so thin. Does that have to be enough?'

As he finished speaking, Richard began to cry bitterly and then to sob. This was a turning point as far as the 'bumping' episodes were concerned. From this session onwards, they began to fade out.

A major part of the psychoanalytic psychotherapy process consists of holding the client in mind. This holding in mind is expressed in many ways, in the provision of a comfortable and reliable setting, in remembering what has been said and in a certain quality of attention, which involves an openness to nuances of emotion. I have suggested that there is also a symbolic form of handling involved, on the basis of the close links between holding in mind and physical handling in infancy. In addition, Richard's decision to talk about the Tai Chi in psychotherapy can be thought about in terms of an unconscious request for assistance in the task of joining up physical and psychological aspects of himself and of his experiences.

By the end of the second year, Richard's episodes of bumping and the harrowing interludes of feeling strange, dissociated and disembodied had ended. A great deal of the third year of therapy was given over to the process of mourning a childhood that seemed realistically to have been quiet and rather bleak. The work continued for two more years, during which time Richard got married and had a child of his own.

In psychotherapy, Richard told and retold the story of his touch experiences. He still remembered his mother as cold and undemonstrative, but, rather than this being a cause for hopelessness, he felt that he could change his story in the longer term. He began to see himself as a survivor who had worked hard to recover. Both psychotherapy and Tai Chi formed a part of this endeavour. And with his recovery came a new sense of compassion towards his parents and the dissolving of his resentment towards his mother.

Towards the end of the therapy, Richard's body storyline of touch experiences also had a future trajectory, involving fantasized experiences of touching and handling his own baby. These imaginings, which might have been worrying if they had appeared in isolation from other changes, were firmly grounded in the steps that Richard had already taken.

Concluding comments

It is not my intention here to elevate one therapeutic approach above another. No doubt different approaches can work well in different hands, with different people, at different times. I hope that, with the help of the case study presented above, I have communicated a sense of how a psychoanalytic practitioner can work with 'touch' without ever making physical contact.

Above all, the helpful factor in play seems to be the opportunity for the client gradually to internalize a therapist who is able to hold in mind both

his emotional and physical needs, and to feel concerned that these needs should be met in a non-destructive way.

Particularly in the clinical example, I have endeavoured to illustrate the importance of the therapist's reflection on somatic countertransference experiences. As well as building the therapeutic alliance at an unconscious level, such reflection can indicate a useful line of enquiry where there is a great deal of material to select from.

Finally, I have tried to show how 'bodywork' undertaken outside the psychotherapy setting – in this case Tai Chi – can support and enhance gains that are made inside the psychotherapy setting. Where the client introduces such essentially physical activities into the therapeutic conversation, we may discern an unconscious endeavour to join up physiological and psychological aspects of experience of 'joining-up'. This process and a request for assistance with that understanding can contribute substantially to the recovery of a good quality of psychosomatic indwelling and thus to health and enjoyment in living.

73 Torbay Road
London NW6 7DU

Note

1 The Squiggle Foundation is a London-based charity which disseminates and develops the work of the late D.W. Winnicott.

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Handling and self-handling: an object relations perspective on leisure exercise.

Psychodynamic Counselling, 6.4: 469 - 488.

PSYCHODYNAMIC COUNSELLING 6.4 NOVEMBER 2000

Handling and self-handling

An object relations perspective on leisure exercise

MAGGIE TURP

ABSTRACT This paper considers participation in exercise activities as a form of 'self-handling'. The focus is on individual exercise rather than on activities, such as those involved in some sports and martial arts, which involve pair or group interaction.

The author suggests that the way in which physical activity is used, abused, or avoided in adult life is linked to the quality of primary relationships and in particular to childhood experiences of handling (Winnicott 1962a, 1970). She suggests that exercise evokes 'memories-in-feeling' (Klein 1957) of early experiences of handling and is thus essentially object related. A number of different psychic functions of exercise are considered in relation both to theory, particularly Winnicottian theory, and to clinical material.

As we are all aware, not everything a client does in the external world is raised for consideration in the context of the therapeutic relationship. The author reflects on the need to consider the meaning of the client's introduction of the subject of exercise into the therapeutic discourse, as well as the meaning of the physical activity itself.

KEYWORDS Psychoanalysis, Winnicottian theory, narratives, exercise, body awareness, countertransference

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INTRODUCTION

> When we provide a swimming pool and all that goes with it, this provision links with the care with which the mother bathes her infant, and with which she generally caters for the infant's need for bodily movement and expression, and for muscle and skin experiences that give satisfaction
>
> (Winnicott 1962b: 69).

Recent discussions with colleagues in and around London have confirmed my own experience: the number of clients raising the subject of exercise in counselling and psychotherapy settings has been increasing steadily over the last few years. This increase mirrors the burgeoning popularity of the 'health club', featuring a gym, exercise classes, and sometimes a swimming pool as well. It also reflects the large numbers of people exercising in other ways, for example by running in the park, exercising at home, participating in a sport or going to yoga or Tai Chi classes.

For many of us, contemporary work patterns and urban lifestyles militate in favour of a markedly sedentary lifestyle. The working life of the counsellor or psychotherapist illustrates the point particularly well! Unless we make a conscious effort to counter the tendency to be desk-bound and car-bound, Winnicott's cited need 'for bodily movement and expression, and for muscle and skin experiences that give satisfaction' is unlikely to be well met. Although Winnicott does not elaborate, I take his description to include a need both for vigorous physical activities and for activities which require physical skill and co-ordination. Self-initiated exercise activities represent an opportunity to meet such needs, at least in part. In order to bring a psychoanalytic perspective to bear on exercise activities, I have found it helpful to consider them, along with touch-oriented activities such as massage (see Turp 2000), as examples of adult 'self-handling'. According to this thesis, self-handling activities relate back in a variety of ways to infant and childhood experiences of being handled by others and are thus essentially object related.

For reasons of space, I have opted to reserve the fascinating subject of exercise and the erotic for another occasion. However, it is worth noting in passing that Winnicott's choice of the phrase 'muscle and skin experiences that give satisfaction' is unlikely to have been coincidental. It gestures towards the close affinity between sensual and

sexual experiences which is so often borne out in our clinical work and by our observations of infants and young children.

An area of communality between different theoretical perspectives within psychoanalysis is the idea that quality of (physical) handling cannot be meaningfully isolated from quality of (psychological) holding. For example, we would not expect to see a child being lovingly carried, cuddled, and rocked at the same time spoken to in an intimidating and humiliating way. Indeed, if we witnessed this scenario, we might feel inclined to question the mental health status of the carer. In normal circumstances, then, quality of handling reflects overall quality of holding.

Winnicott's attribution of special psychological functions to the physical aspects of care is a distinctive feature of his account of early object relations. It is physical handling and care which particularly invokes experiences of muscle and skin and which enables the infant to achieve a sense of his or her own boundaried and embodied being. Considerable evidence has accrued, both within and outside psychoanalysis, to support the proposition that skin and muscle experiences play a special role in human infant and mammalian development (see, for example, Spitz 1945; Harlow and Harlow 1962; Barnard and Brazelton 1990; Hopkins 1990; Field 1995).

Psychoanalytic thinking in this subject area has focused primarily on touch experiences. Drawing on Jungian writing (e.g. Blackmer Dexter 1989), on psychoanalytic infant observations, and on clinical experience, I have argued that there are significant overlaps, both physiological and psychological, between experiences of movement and touch (Turp 1999a). Touch and movement tend to co-occur – in the womb, in infancy, in childhood, and in adult life. Physiologically, both involve receptors at the site of the skin and located within the muscle mass. These receptors which respond both to external pressure and to movement and postural change, whether self-initiated or initiated by a third party. So significant are the overlaps that I believe we can only realistically speak in terms of self-handling which emphasizes touch and self-handling which, as in the case of exercise, emphasizes movement. Some activities such as swimming confound even this distinction, since they involve movement and touch experiences in apparently equal measure.

USES AND ABUSES OF EXERCISE

Like maternal handling, self-handling can be more or less appropriate and sustaining, more or less psychologically useful. At best,

it contributes to the sense of continuity which Winnicott called 'going-on-being' and to the sense of being all of a piece within a skin described as 'personalization' (1945) and as 'the psyche indwelling in the soma' (1970). At worst, it overrides a normal tendency towards self-care and is used in an obsessional and self-punitive manner, confirming the body as a 'not-me' object.

In relation to these contrasting functions of exercise (which I do not hold to be mutually exclusive and which by no means exhaust the possibilities), I should like to contribute some further thoughts. First, primarily through the evocation of 'memories in feeling' (Klein 1957), exercise may help to keep early experiences of good handling alive as a resource in the present. This resource supports our physical vitality, our ongoing enjoyment of physicality. By sustaining and strengthening the psychosomatic linkage, exercise militates against psychosomatic numbing and splitting in the face of difficult circumstances and emotional affronts. Second, obsessional, self-punitive, or unduly narcissistic use of exercise often seems to make sense in terms of a re-staging of neglectful or inappropriate handling experiences in infancy and childhood. Thus, although exercise abuse may contribute substantially to a pathological clinical picture, we should not overlook the possibility that a healthy tendency is also being expressed. A description of exercise abuse may be the client's way of calling our attention to long-standing difficulties in the arena of psychosomatic indwelling.

In psychodynamic work, the narrative itself is considered alongside the possible meaning of the introduction of a particular topic into the therapeutic dialogue at a particular moment. When the subject of exercise is raised in the therapeutic setting, we will have in mind a number of different questions. How is the exercise being used or abused? Why has exercise entered into the narrative at this point? What is the client unconsciously seeking in telling us about their experiences with exercise? As always, our understanding of what is being played out and our response to it is crucially important. When all goes well, it enables the client to abandon exercise abuse and/or to engage in more creative uses of movement activities.

D.W. WINNICOTT AND THE PHYSICALITY OF THE SELF

Meanings of activities change over time, since all activities are embedded within a constantly shifting cultural context. From a post-modern perspective, it can be argued that Winnicott stood for

'freedom and creative advance' rather than for 'order and system' (Levinas 1961: 17). Because he resisted organizing his concepts into an overarching metapsychology, different aspects of Winnicott's work emerge as related to each other in an informal rather than a formal way. The lattice-like organization – some would say disorganization – of Winnicott's ideas leaves room for individual discovery and for new connections to be made as circumstances change. The contemporary phenomenon of mass participation in leisure exercise post-dates Winnicott's work. Nevertheless, his thoughts on handling in infancy and childhood lend themselves quite readily to the exploration of this phenomenon. 'Being loved at the beginning means being accepted . . . the child has a blueprint for normality which is largely a matter of the shape and functioning of his or her own body' (Winnicott 1970: 264). A number of psychoanalytic writers have noted the emphasis placed by Winnicott on physicality, on the importance he accords to the possibility of simply 'going-on-being' within the body. Adam Phillips sees this close attention to the establishment of psychosomatic unity on the one hand and to defensive psychosomatic splitting on the other as the hallmark of Winnicott's work:

> [In Klein's account], the infant's initial developmental project was to deal with the psychic pain consequent upon his innate sadism. In Winnicott's quite different model the infant's project was, through sufficient maternal care, to inhabit his body. . . . Winnicott put at the centre of his developmental model not a mythic conflict between incompatible forces but 'the localisation of self in one's body'.
>
> (Phillips 1988: 78)

Susie Orbach has also commented on the distinctiveness of Winnicott's work, as located within a historical context:

> [But] in post World War Two developments, psychoanalysis has now become primarily a theory of mind and mental contents. Winnicott's work stands out from this tendency in the deeply physical sense that he conveys to us about his work and his understanding of mental processes.
>
> (Orbach 1995: 3)

The idea of the essential physicality of the self, which was not in vogue during Winnicott's lifetime, has gained a great deal of ground within contemporary philosophy, as challenges to dualistic notions of 'body' and 'mind' have become more telling: 'The basic subject is (therefore) a mental and physical subject-object physically extended in space. Hence, Cartesian dualism is inconsistent with a correct account of the nature and content of bodily awareness' (Brewer, in

Bermudez *et al.* 1995: 303). A similar perspective emerges from the work of the eminent neurologist Antonio Damasio. Damasio (2000) identifies the roots of a sense of singularity in the reality that we each have one body. He argues that 'the part of the mind we call the self' is grounded on a 'collection of nonconscious neural patterns standing for a part of the organism we call the body proper'. These developments are compatible with the suggestion I make here, namely that both creative uses and abuses of physical exercise speak wordlessly of the whole thinking, feeling, remembering self.

This suggestion, a thread which runs through my work, is based primarily on clinical experience and infant observation. Recently though, I also conducted a very small piece of survey research at my local gym. To each of the first twelve individuals to finish the aerobic part of their programme after I arrived, I posed the following question: 'What kind of things were on your mind when you were walking (running, cycling) today?' I received a wide range of different responses, which did not fall into any obvious categories. One woman told me: 'Actually, I wasn't really here at all. I was already out on the hills in Majorca. I'm going walking there at Easter with my partner.' A man told me 'Nothing – and I'd rather keep it that way. This is the only place where I don't think, where I can manage to clear my mind. [Laughing] I suppose you could call it a kind of meditation.' Another woman also began by saying 'Nothing', then went on after thinking for a while: 'I just like the feeling of my muscles working. It's a straightforward thing – not complicated. Most things are so complicated.'

This was not an in-depth piece of research and I do not want to set too much store by the responses. Clearly, the respondents are likely to have edited their responses and to have screened out erotic, or troubling thoughts and fantasies. Nevertheless, I found it interesting that none of the twelve responses referred to 'body-as-object' topics such as losing weight, building muscle, or increasing attractiveness. These responses give some grounds for hope that leisure exercise is more often being used in a psychologically sustaining manner than in an abusive, self-punitive way or overly narcissistic manner.

THE 'JOINING UP' OF PHYSICAL AND PSYCHOLOGICAL EXPERIENCE

To start at the very beginning, Winnicott refers to the crucial importance of a mother's ability (or lack of ability) to join up

physical and psychological aspects of her own and of her infant's experience:

> The beginning of that part of the baby's development which I am calling personalization, or which can be described as an indwelling of the psyche in the soma, is to be found in the mother's ability to join up her emotional involvement, which is originally physical and physiological.
>
> (Winnicott 1970: 264)

This joining up rests on the process described by Winnicott as 'primary maternal preoccupation':

> The healthy pregnant woman becomes mentally 'ill' just before giving birth and for a few weeks after birth. This unique state is called by Winnicott 'primary maternal preoccupation'. The psychological and physical health of the baby, according to this thesis, depends on whether the mother is able to go into and come out of this special state of being.
>
> (Abram 1996: 231)

In ordinary 'good enough' circumstances, this joining up begins before the baby is born, as the mother-to-be shifts from seeing herself as 'pregnant' to feeling herself to be in relationship to an unborn child, with personal characteristics of his or her own. Stroking the infant in the womb through the skin of the abdomen, attributing intentions to unborn the infant ('I see you're in no mood to let me have a sleep!') and asking questions ('How are you doing in there? Is it getting a bit squashed, eh?') are some of the external markers of this shift. The basis of these developments is the identification of the mother with the baby, based on her unconscious recollection of her own experience as a baby. This identification brings into play the active adaptation by the mother to her individual baby, which is the holding environment. Once the child is born, then, the mother's ability to 'join up' the psychological and the physical is communicated through maternal care, where being held in mind and being physically handled are enjoined in a seamless continuity. Winnicott suggests that such maternal handling meets with and supports an inborn tendency within the infant towards integration. Adam Phillips describes this rather beautifully: 'This natural "tendency to integrate" is made possible by the mother's care in which the infant is "kept warm, handled and bathed and rocked and named" ' (1988: 79). Winnicott emphasizes that the handling aspect of this care needs to be individually tailored to a particular infant and enjoyed by mother and infant alike in order to qualify as 'good enough':

> The baby takes for granted all the things like the softness of the clothes and having the bath water at just the right temperature. What cannot be taken for granted is the mother's pleasure that goes with the clothing and bathing of her own baby. If you are there enjoying it all, it is like the sun coming out for the baby. The mother's pleasure has to be there or else the whole procedure is dead, useless, and mechanical.
>
> (Winnicott 1949: 27)

Good-enough handling ushers into being a sense of 'personalization' (Winnicott 1945) which is synonymous with 'the indwelling of the psyche in the soma' (Winnicott 1970). We might also describe this phenomenon in terms of a feeling of proper embodiment or of being all of a piece within a skin. It is in his repeated references to the issue of 'indwelling' (1960a, 1962a, 1962b, 1966, 1967, 1970) that the essentially holistic nature of Winnicott's perspective on the human subject emerges most clearly. As Abram has written, 'For Winnicott, in healthy development, psyche and soma are not distinguishable as far as the infant and developing child are concerned. The healthy individual takes it for granted that his sense of self is part and parcel of his body' (Abram 1996: 237).

The idea of a sense of self centred in the body as a key precondition for healthy and enjoyable living reverberates through the whole of Winnicott's work. In 1960, he introduces the concept of a 'True Self', a secret core of the individual which is never fully revealed but which is the source of spontaneity, authenticity in relationships, and creativity. The True Self is strongly linked to physical functioning and is described by Winnicott as 'little more than the summation of sensory-motor aliveness' (1960b).

This elusive True Self element is expressed in the infant's 'spontaneous gesture' (Winnicott 1960b), the part of the infant's repertoire which comes from his innermost sense of his own being. It may be something as simple as his physical indication of the way he likes to be held and feels comfortable. It is the mother's ability to receive and respond to the spontaneous gesture which facilitates the development of a sense of self emanating from the True Self. If the spontaneous gesture is overlooked or overridden, Winnicott suggests, there may be later difficulties with symbolization. He emphasizes that the infant's gesture is given meaning and sustained only if it is recognized and implemented by the mother.

In summary, Winnicott suggests that good-enough handling establishes and supports the unity of the psyche-soma, experienced by the individual as 'indwelling'. Indwelling underpins psychosomatic

health, supporting a robust sense of embodiment and a good level of body awareness. Because it is strongly linked to the True Self elements of spontaneity and creativity, indwelling also underpins the capacity for authentic self-expression and enjoyment in personal relationships.

CULTURAL AND PSYCHODYNAMIC PERSPECTIVES ON EXERCISE

Our thinking about an individual's use of exercise is informed by a context of broader cultural perceptions. One cultural reading condemns the exercise phenomenon out of hand, seeing it as evidence of a deepening split between psychological and somatic aspects of the self. Within this frame, leisure exercise activities are seen as rituals enacted in accordance with narcissistic and obsessional tendencies. This is the perspective often echoed in psychoanalytic writing. A second reading characterizes engagement with exercise as a broadly healthy tendency, an appropriate response to the reduction in physical demands made upon us by daily living. From this perspective, the exercise phenomenon represents an endeavour to strengthen and conserve the integrity of the psyche-soma in the face of an increasingly sedentary lifestyle and a post-modern preoccupation with appearances and surfaces, including the appearance and surface of the body-as-object. A third reading idealizes exercise, seeing it as the road to perfect physical and mental health, to a place where we are no longer subject to the givens of existence and are immune to suffering. Adam Phillips has written recently about various myths of perfection, among which I include the myth of 'perfect health'. In the passage below, he refers to the thinking of Freud and of Darwin:

> We have been looking, they suggest, in the wrong place, for the wrong things; spellbound by ideas of progress and self-knowledge only to discover not that, as we already knew, such things were difficult and demanding, but that they quite literally did not exist, and didn't give us the kinds of lives we wanted.
>
> (Phillips 1999: 17)

My own encounters with exercise narratives have made me aware that exercise may fit into any, or at times into all, of the perspectives outlined above. Face to face with a specific individual's relationship to his or her chosen exercise activity, it is complexity rather than simplicity that we encounter.

We shall continue to be handicapped in our work if we can think coherently only about the pathological aspects of the exercise

scenario described to us. Lacking a theoretical context into which they may be received, we run the risk of overlooking the health-seeking strands entwined within the whole. We are in need of concepts to help us identify and name – to ourselves and/or in the therapeutic dialogue – a shift on the client's part away from exercise abuse and towards beneficial engagement with exercise. Also, we need a way to think about the *avoidance* of physical self-expression, which was a primary issue in my work with 'Sandra', described below.

CASE EXAMPLE OF 'SANDRA'

A client 'Sandra' had been attending counselling once a week for four months. Her appearance was strikingly pale and listless. When she arrived, she would curl in a semi-sitting foetal position on the couch and remain in that posture until the session ended. She spoke quietly and haltingly. Anything I said risked reducing this meagre flow of words to nothing. Sometimes, after I had made a comment which I thought might be helpful, Sandra would dry up completely and spend the rest of the session staring blankly at the wall.

In the sessions, I began to notice myself sitting up straighter than usual, taking deep breaths, stretching out my limbs as if I myself might fall into a torpor. I caught myself thinking that Sandra ought to get out and get some fresh air and wondered what this thought and the accompanying feeling of irritation might mean. Often I felt in good form at the start of a session but tired and unwell after only ten or fifteen minutes. I became more aware of how draining I found the situation. Sandra would not let me be helpful to her and I was beginning, quite inappropriately, to want her to 'buck herself up'. An aura of depletion and immobility pervaded the consulting room.

As is so often the case, Sandra's physical inertia was part of a more general depression, which had been recurrent throughout her adult life and which on this occasion had lasted for almost two years. Increasingly aware of my own physical restlessness when I was with her, I encouraged Sandra to talk about the physical shape of her days. She told me, in a wooden tone, that she sometimes spent whole days in bed, reading or watching the television. It was very difficult for her to get out of bed to come to see me, as the walk to the bus-stop felt like an insurmountable obstacle.

I told Sandra that I felt a sense of depletion, almost of deadness, both in the situation she described and in sessions, where she often seemed to find herself unable to move or speak. I made a link to

the sessions (about one in four) which she missed, her usual explanation being that she had failed to get up. Sandra's response was to sigh and say: 'It just feels like too much trouble.' Quite spontaneously, but perhaps informed by my earlier reflections, I asked: 'Too much trouble for me or too much trouble for you?' 'Both, really', said Sandra. 'I expect you're relieved if someone doesn't turn up. It gives you a bit of a rest. But then again, I can't really be bothered either.'

This comment turned out to be the key to important changes. I said to Sandra that she portrayed a situation where neither party really had the energy to go on. Nothing could happen. Nothing could change. Sandra immediately thought of her mother, who had told her that she suffered from post-natal depression, made worse by the fact that Sandra 'cried all the time' for the first few weeks of her life. This depression had been spoken about before, but in a very concrete manner, with Sandra simply saying that she supposed her mother's tendency to depression had genetically pre-disposed her to becoming depressed herself.

This time, Sandra said that, when I had spoken, she had suddenly had a 'flash' of what it was like when she was a baby. She was obliged to stop crying and to be quiet and undemanding. She knew her mother couldn't cope with a lively, noisy baby. I pointed out to Sandra that her sense of having to be small, still and quiet was also present in her relationship with me. She assumed that my resources, like her mother's, were entirely inadequate. She gave me sessions off by staying home, in case she should prove too much for me.

By now, more fully aware of the projective identification processes in play, I recognized that I too had begun to feel constrained, to feel that I could not be 'noisy', could hardly speak for fear of disabling Sandra altogether. I too had felt hopeless, listless and irritated. I too had felt that I had no power to change the situation. I was able to say to Sandra that she had found it imperative to let me know about the key features of her early experiences with her mother. We went on to name these features together, with Sandra recognizing each element and expanding upon it, inserting details which she remembered from later on in her childhood.

It was clear from the changed atmosphere in the consulting room that important changes were occurring. Things also began to change in the outside world too and one of the first markers of these changes was an increase in physical activity. Rather to my surprise,

Sandra arrived one day and told me about what might be described as 'getting out and getting some fresh air'. The story was as follows. Sandra had found herself wanting to go for a walk. She was quite excited by this impulse as it was so long since she had felt anything like it. She dug an old pair of boots out of the cupboard, put them on and went for a long tramp through one park and then through another. Sandra smiled at me and said: 'You know, I felt actually healthy. I can't remember when I last felt like that.' I asked her what it meant to her to feel healthy. After a long pause, she replied that she thought it meant that she was beginning to feel more hopeful about the future.

I have included extracts from this particular piece of work because it is so much easier to overlook exercise avoidance than to overlook exercise abuse. And yet, the avoidance of physical activity may also 'speak volumes'. Similarly, we may more readily recognize a 'spontaneous gesture' which takes the form of a specific action than one characterized by a particular style of being in the room, in this instance a style characterized by a lack of movement and liveliness. In my work with Sandra, countertransference experiences, particularly somatic countertransference experiences, led the way in the task of bringing meaning to the client's marked stillness and lack of physical vigour, which was an authentic although unconscious communication from her to me.

The good-enough holding environment I was able to provide seems likely to have been implicated in the subsequent emergence of a different spontaneous gesture – the desire to go for a walk. Our continuing conversation revealed that Sandra was able to hold me in mind as a person who was sensitive to her different mood states and ways of being, and who would share her sense of pleasure and excitement about the walk. She told me rather shyly, 'I was looking forward to telling you. I knew you would understand what it meant to me'.

INDWELT BODY AND BODY AS OBJECT

It may be useful to make a distinction between the body experienced from within, which I shall call the 'indwelt' body, and the body experienced as if from the outside looking in, which I shall call the 'body as object'. Winnicott's reference to 'muscle and skin experiences that give satisfaction' calls to mind the indwelt body, which is an aspect of our self-experience which begins in the womb. The indwelt body

– the site of our 'indwelling' – becomes an integrated aspect of who we feel ourselves to be, provided it is supported by good-enough handling.

Where the client's engagement with exercise clearly relates to 'muscle and skin experiences that give satisfaction', we may assume the involvement of the indwelt body. We can perceive a healthy core, around which the exerciser's exertions are organized. The exercise is object-related, in so far as experiences associated with good-enough handling are in some way being replayed. In these circumstances, there is no difficulty in seeing the exercise as a benign form of self-handling, with the potential to preserve and carry forward the mother's integrated care of the infant, including her concern with the infant's physical comfort, enjoyment and health.

The body as object, perceived by others and by ourselves as if from an external point of view, becomes a part of our consciousness at a later stage. Because internalized versions of external perceptions of the body have an enormous capacity to fuel narcissistic or self-punitive tendencies, the body as object is often seen as necessarily problematic. And yet, it is the case that the body is an object in the external world as well as the site of our indwelling. A concept such as self-esteem is embedded in our acceptance of this reality, for it incorporates the idea that we perceive ourselves as being perceived by others. For better or for worse, the way in which we think we are seen becomes an important part of our identity.

In some situations, though, body-as-object elements may emerge as pathological. Many of our clients have had poor experiences of handling. Responsive touch may have been lacking or there may have been sexual or physical abuse. These are the situations in which we are likely to encounter descriptions where the body is being related to primarily as a 'not me' object. Sometimes a pervasive sense of physical self-hatred is revealed when a client makes self-deprecating comments. One client told me: 'I look in the mirror and what I see is a stupid, fat cow.'

Even in this situation, we may be aware of a health-seeking element inherent in the client's presentation of exercise abuse in the therapeutic setting. In describing his or her treatment of the body as a 'not-me' object, is the client unconsciously requesting the practitioner's help in joining up the physical and the psychological? According to Winnicott, physically expressed disturbance, particularly where it is brought into in the arena of the consulting room, carries the unconscious hope that difficulties for which the client has

no words will be recognized and that help will be forthcoming. Although Winnicott's comments refer specifically to psychosomatic illness, I suggest that in cases of exercise abuse as well 'there is in the symptomatology an insistence on the interaction of psyche and soma, this being maintained as a defence against threat of a loss of psycho-somatic union, or against a depersonalization' (Winnicott 1962b: 62).

In view of the different possibilities in play, it is vital to consider carefully the balance between the attention directed towards the body the client sees (or thinks she sees) reflected in the mirror and the attention directed towards the body experienced from within. Through psychodynamic work, a shift from a predominance of body-as-object elements to a more balanced picture may be achieved. This possibility was illustrated in the case example of 'Betty' described in a previous paper (Turp 1999b).

CASE EXAMPLE OF 'SHEILA'

I have suggested that engagement with exercise may stand as a form of 'self-handling', expressing an endeavour to sustain a good enough sense of indwelling or to repair a disturbance of indwelling – a 'weakness of linkage between psyche and soma' (Winnicott 1966: 113). The work with Sheila described below suggests that such a weakness of linkage can have its origins in later childhood trauma as well as in the holding and handling difficulties in infancy illustrated in the previous case example and emphasized by Winnicott.

Sheila was born in the North of England. She was an only child, whose mother died in a traffic accident when Sheila was 12. Unable to recover from the loss of his wife, her father took to drinking heavily. He was able to hold down his job but was never home in the evenings. Sheila was left to more or less bring herself up. An uncle befriended Sheila, calling round to see her and helping her with her homework. This uncle soon began to sexually abuse her. For several years, while the abuse continued, Sheila cut herself secretly on her arms and legs. When she was 16, she persuaded her father to give her £500, left school and travelled to London.

Looking older than her years and helped by her attractive figure, delicate features and natural acumen, Sheila succeeded in getting a job as a receptionist in a very smart London hotel. In the place of her real past, she invented a past for the benefit of her colleagues,

and perhaps also for her own benefit, saying that her parents had recently moved to Australia to live near her (invented) older brother and their two grandchildren. Sheila made no further contact with her father and did not give him the address of her rented bedsitter.

These are the bare bones of Sheila's history. When she arrived in my consulting room, she was 23 years old and extremely thin. Although her self-injury had ceased, she had a history of anorexia going back for five years. Her eating disorder had twice become so severe that she had been admitted to hospital. When she first consulted me, she had just emerged from her second, six-week, hospital stay, which had been precipitated by her dangerously low body weight. With characteristic inventiveness, she had got the time off from her employers by telling them that she wanted to visit her family in Australia. Sheila laughed when she told me this but I noticed that I felt close to tears. Her fantasy of a real family – parents, a brother, a niece and a nephew – in the place of her non-family struck me as intensely sad.

Sheila spent much of the first year of therapy describing to me what she did, and did not, eat. I can summarize by saying that, essentially, Sheila ate very little, never consuming what we would normally think of as a 'meal'. She would only eat 'pappy' food: white bread, flavoured yoghurt, mashed potato and ice cream. She would only eat on her own in her room. She was embarrassed by an excessive amount of body hair, which was a side effect of her anorexia. She had not had a menstrual period for over two years.

An eating disorder can form a part of many different narratives. In Sheila's case, the desire to take complete control, to 'begin again' as if the past had not happened, was a striking feature of her way of managing her difficulties. Self-denial was also an important theme. Sheila denied herself not only the enjoyment of food but also the enjoyment of sociability. Outside working hours, Sheila lived a very isolated life. She told me that she saw no real prospect of a sexual relationship or a family life. Envy and self-denial were entangled in a complex way, with each fuelling the other. At one point, I suggested to Sheila that her eating disorder was designed to communicate the following message to me and to the world in general: 'You haven't looked after me enough and I'm damned if I'm going to do it for myself. I won't give you the pleasure of seeing me thrive, but will force you to see instead that I am hungry and neglected.' Sheila flashed me a shocked and angry look.

Soon afterwards, Sheila began to mention that she wanted to start to go swimming. I was immediately concerned, as I knew that she had abused exercise in the past. In fact, she had described 'jogging' for half an hour at a time in the toilet of her inpatient unit, to work off the food she had been made to eat. I voiced my anxieties and this led to a conversation about what the swimming would be for. Sheila assured me that she wanted to do it as 'something nice', not to punish herself. She told me she had taken to heart my comment about her refusal to look after herself and enjoy herself and had caught a glimpse of her own resentment and of the way she spoiled things. She had felt angry with me but unable to deny the truth of my words.

Following this exchange, we were able to consider together the paucity of touch and movement experiences in Sheila's life and her need for physically pleasurable experiences. In this way, I gave her plan to go swimming my rather cautious blessing. Nevertheless, I remained concerned that Sheila might use swimming in an obsessional way or self-punitive way and wondered whether she would eventually reveal that she was meticulously counting lengths and calculating calories burned. In the event, my anxieties proved to be unfounded. Sheila spoke to me about the pleasure she felt in being supported and stroked by the water as she swam. I began to think about her swimming in terms of an endeavour to rejoin physical and psychological aspects of her experience, which had been split apart by the dual trauma of losing her mother and sexual abuse.

Throughout this time, Sheila depended heavily upon my interest and understanding, telling me about the temperature of the pool, the strokes she could do and could not do, the peak and off-peak costs of a swim and so on. On one occasion, she brought in two new swimming costumes and held them up for me, asking for my opinion as to which one I thought would suit her best.

Psychoanalytic technique does not usually include offering advice of this nature. On this occasion, though, I was so poignantly reminded of the young teenage girl who has no mother to advise her in the ways and conventions of womanhood that I decided to give her the advice she requested. I was increasingly aware of the erotic elements entering into Sheila's transference to me, present in her wish for me to consider her attractiveness in one or other of the costumes and in a variety of other ways. However, my countertransference at this time was far more maternal than erotic and so I let the erotic material lie and commented instead on the

difficulties of having to negotiate the transition to womanhood without a mother. Sheila cried and cried when I said this. Thus she embarked on the task of mourning her mother's death, something that had been impossible at 12 years old in an unsupported situation.

With the swimming came an increasing willingness and capacity to take care of herself in a number of different ways. Sheila managed to initiate and keep up a programme of good dental hygiene, and to visit the dentist. This was no small matter, as her teeth and gums had suffered terribly from her disturbed diet. She made efforts to eat nutritious food and at the same time her enjoyment of food increased enormously. She told me she 'almost died of embarrassment' when she ran into a work colleague at the swimming pool. However, they ended up swimming together regularly and going out for a snack or a drink after their sessions at the pool.

Gradually, I began to notice that Sheila was 'growing up' physically. Over time, she began to look more womanly, more attractive, stronger and fitter. Eventually, she began to talk about having a sexual relationship and said that she thought it would be with a woman. This signalled to me her readiness to explore her erotic and loving feelings towards me and opened up another area of work in the therapeutic relationship.

What I have described is a small fragment of seven years of work, with sessions taking place twice and, for a shorter period, three times a week. For somebody like Sheila, who had been deprived of maternal care from the age of 12 and who had come close to destroying herself, I think that a treatment of this length may be the only road to a significant recovery. The extent of this recovery became clear to me towards the end of our time together, when Sheila initiated a reassessment of her early care. She brought in photographs of her mother and showed them to me, pointing out to me how beautiful her mother was and how tenderly she held Sheila as a baby. It had taken seven years of therapy, overlapping with six years of swimming, to really have a sense of the care she had received in the first twelve years of her life.

Winnicott suggests, in the passage quoted at the beginning of the paper, that the activity of swimming has the capacity to arouse memories-in-feeling of being bathed and attended to in infancy. Earlier still are unconscious memories of floating and tumbling in amniotic fluid inside the womb. The rhythmic kicking involved in swimming may also serve to remind the swimmer of the feeling of

kicking as a baby and perhaps of the responses evoked by his or her movements. Given the presence of this range of potential conscious and unconscious associations, it is perhaps not surprising to find that swimming can play a very special role in overall recovery.

CONCLUDING COMMENTS

I have considered the value of regarding a communication on the subject of exercise, or lack of exercise, as an unconscious request for assistance in the task of joining up physical and psychological aspects of the self. I have argued that a description of avoiding physical activity or of engaging in self-punitive exercise may reflect either early deficits in handling or later traumatic experiences, which have been psychically survived only as a result of the client splitting off mental processes from physical self-experience.

The counselling or psychotherapy environment provides an unusual opportunity for the client both to re-stage the psychosomatic split and to enlist the practitioner's help in instituting or consolidating 'a psyche-soma that lives and works in harmony with itself' (Winnicott 1967: 29). As is implicit in the clinical work described, our ability to work effectively with exercise-related narratives depends in part upon our own well-grounded sense of indwelling, which is the basis for our receptivity to somatic aspects of countertransference phenomena. To say this is, of course, to re-articulate, in a particular way, the central psychodynamic understanding that the practitioner's capacity to reflect on various facets of his or her internal world is indispensable to the success of the therapeutic process.

Maggie Turp, part-time researcher and lecturer at the University of Hertfordshire, psychotherapist and supervisor in private practice, 73 Torbay Road, London, NW6 7DU (E-mail MaggieTurp@aol.com)

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A response to "Three bodies in psychotherapy" by John Rowan.

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A response to 'Three bodies in psychotherapy' by John Rowan

Maggie Turp
University of Hertfordshire

Ψ

My first association to the title of John Rowan's paper 'The three bodies in psychotherapy' was an image of couples therapy, where there are indeed three bodies in the consulting room. But the paper turns out not to be about clinical work, not about the physical experience of being in the room with other (necessarily embodied) human beings in the heightened atmosphere of the therapeutic encounter.

What the paper does offer is an account of three conceptual frameworks for thinking about the body. Overall, the pedagogic and pragmatic tone of the piece implies that the issues involved are relatively straightforward. No matter that the nature of physical, mental and spiritual aspects of the self has been the subject of argument and conjecture since the dawn of philosophy. No matter that a final consensus seems as remote as ever. No matter that these debates are embedded, as has been the case from time immemorial, in a complex social and political power play.

Take, for example, Cartesian dualism, Rowan's 'Level One'. Descartes himself was a mass of contradictions. He was a devout Christian and his pronouncements reflected a heartfelt desire to see humans as God's creatures, distinct from the other animal species. He was a key figure in the development of rationalism and modernism and yet, according to his account, the model of dualism came to him in a dream.

Dualism assisted the church in its endeavour to protect its power base. If humans had both a body and a soul, while animals had only a body, then the church could claim a valid and indispensable role in ministering to the human soul. At the same time, Descartes' decision 'to divide each difficulty I should examine into as many parts as possible, and as would be required the better to solve it' (Descartes 1654) led rapidly to the waning of religious influence. It fuelled the positivistic and reductionist tendencies which would eventually lead to the decline of the church as a power, and to the

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establishment of science as the new god of truth and knowledge. History is, of course, littered with such long, slow, own goals.

The point I am making is that *nothing* in this area of discourse is remotely as straightforward or as easy to pin down as Rowan would have us believe. Take another example, the example of Freud, to whom Rowan accords a passing mention and who is designated a 'Level One' thinker. Did Freud really see the body in dualistic terms as a simple example of 'matter', as devoid of meaning? The whole idea of conversion hysteria and the efficacy of the 'talking cure' in alleviating physical symptoms screams against such a conclusion. And yet it is also true that, alert to potential accusations of quackery and endeavouring to gain a foothold for psychoanalysis in medical and scientific circles, Freud couched many of his early communications in quasi-dualistic language.

Rowan explores Level Two, Wilber's (1996) 'Centaur' level, in rather more detail. This section of the paper consists primarily of a lengthy overview of various forms of 'hands on' psychotherapy, primarily bodywork psychotherapy. There is a clear implication that such forms of psychotherapy have an exclusive claim to a 'bodymind unity' perspective on the human subject, with which I wish to take issue

A more telling argument in my view is that bodymind unity implies that physical and verbal phenomena are simply coexisting facets of the one thinking, feeling, imagining and embodied whole person. Because 'body' and 'mind' categories do not exist, there is no impediment to the idea that a 'physical' experience, such as a long walk or a massage, affects 'mental' experience – feeling, thinking, and so on. There is much in everyday experience to confirm that this is the case. Most of us have personal experience of the tremendous psychological well-being which can be engendered by intense physical experiences – making love, skiing, climbing a mountain. Physical activity can affect intellectual as well as emotional functioning. The English composer Benjamin Britten is known to have taken long 'thinking walks' when he felt low on ideas and inspiration. There is ample support here for the bodywork psychotherapy claim that psychological changes can be effected through physical techniques.

Equally, the concept of bodymind unity supports the psychoanalytic claim that it is possible for physical states to be profoundly altered as a result of verbal interaction. If a dialogue, therapeutic or otherwise, affects the unitary whole person, then we may expect changes in both physical and psychological dimensions of functioning. Again, examples are easy to come by. When we are anxious and waiting for news, we may suffer symptoms of physical tension, shallow breathing, a feeling of stiffness, perhaps nausea. A telephone call to tell us that a friend's operation has gone well or that a loved person has arrived safely at his or her destination brings an immediate change of physical state. While Rowan superficially rejects a dualistic

perspective, it seeps out in the implication that only practitioners who actually touch the fleshly body address the physicality of the human subject.

The more radical, but in my view inevitable, implication of the bodymind argument is that we all address the physicality of the subject all of the time. Words are physical; touch and movement are psychologically meaningful. Psychoanalytic practitioners work with the dimension of physicality primarily through their reflections on somatic aspects of countertransference experiences stirred up within them through being in the room with the client, through being with the client's presence, posture, and words. Nathan Field (1989), briefly mentioned by Rowan in a different context, has written about feeling abnormally cold, about falling asleep, about sexual arousal. Susie Orbach (1995, 1999) has written extensively about the physicality of the experience of being in the room with a client. A part of the bodymind unity discussion also concerns the physicality of words:

> By implication, psychoanalytic interpretation, like all verbal expressions, cannot escape intimate links with the body. It is inseparable from sounds that are emitted physically, and thus from intonation, volume, rhythm and other forms of primitive enactment.
>
> (Likierman 1993)

In his discussion of 'Level Three', the 'subtle body', I hoped Rowan might address some of these matters, might comment on the subtleties of somatic aspects of transference and countertransference, of non-tactile body-to-body communication. For there is indeed something mysterious and ephemeral about unconscious to unconscious communication, particularly when it emerges in the form of the therapist falling asleep, or developing a headache which disappears within minutes of the client leaving the room. In the event, this last section of the paper reads rather like a user's guide to spirituality, complete with the warning that 'the spiritual path . . . is not something to jump into naively'.

Rowan has written extensively on transpersonal psychotherapy and there was an opportunity here to discuss the overlaps and distinctions between 'spiritual' and 'psychological' phenomena. Although Rowan states in the introduction that Level Three will be accorded the most attention, this section turns out to be rather shorter than the Level Two section. I wondered why this was so. Could it be that much that might have been included in Level Three had already been described under Level Two? In Level Two, for example, there is an account of the 'seven chakras' perspective, a perspective which might seem to fall more naturally within spiritual/subtle body (Level Three) considerations. What seems to emerge is the complexity of the situation. As far as I am aware, there is no agreed way of distinguishing between psychological and spiritual phenomena, and

it may be the case that such a distinction is impossible. Again, the issues involved go back a long way, both in philosophy and in psychoanalysis. Bettelheim (1983), for example, has highlighted the fact that Freud wrote extensively about 'the soul' – *die Seele* – which only later, in translation, became 'the psyche'.

John Rowan includes a wealth of useful references, particularly for readers who are interested in bodywork and transpersonal therapy but who are unfamiliar with the literature. As it proceeds, however, the paper becomes more and more akin to a popular self-help book, complete with recipes for doing therapy well. I wonder, was I the only person to find the snippets of advice just a little patronizing? In the bullet points we are advised: 'don't pull green apples'; 'don't get too enthusiastic'; 'don't be intolerant'; and (rather bizarrely) 'keep eye contact at all times'. This simplistic rendering is disappointing, coming as it does from one of the best-known figures in humanistic and transpersonal psychotherapy. It does little justice to the real-life complexity of the therapeutic encounter.

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The many faces of self-harm.

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The many faces of self-harm

MAGGIE TURP

ABSTRACT This paper outlines the development of a broad descriptive account of self-harming phenomena. The author suggests that self-harm is not, as is sometimes assumed, a phenomenon that can be readily identified and circumscribed. She introduces a 'continuum' model of self-harm, encompassing behaviour ranging from 'good enough' (Winnicott 1960) self-care at one end of the scale to severe self-harm at the other. She draws attention to the frequently encountered but little discussed phenomenon of self-harm by omission, and identifies a class of behaviours referred to as 'cashas' – *c*ulturally *a*ccepted *s*elf-*h*arming *a*cts/activities.

Qualitative research, taking the form of conference workshop and supervision group discussion of clinical material, is presented. Self-harm is revealed as a diverse phenomenon, one that takes a multitude of forms, each of which may be enacted at various levels of severity. 'Hidden' manifestations of self-harm are discussed as well as the 'high visibility' manifestations that are the central focus in much of the literature.

The tendency towards stereotyping in relation to self-harm is examined. The author questions the wisdom of attempting to arrive at any generalized account of the cause, function or meaning of self-harming behaviour. In recognition of the complexity of situation, she suggests that 'there is no single explanation for self-harm, no single meaning or communication conveyed by self-harm and no single psychological disorder or personality profile associated with self-harm'.

KEYWORDS Self-harm, phenomenology, transgression, qualitative research, psychoanalysis, practitioner containment

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INTRODUCTION

I still hurt myself in lots of ways, really. Worrying, blaming myself for things, doing too much, not letting myself sleep – they're just as bad for me.

('Woman A' in Arnold 1995: 8)

In much of the literature and in many people's minds, the term 'self-harm' is reserved for obvious acts of self-directed violence, in particular repetitive self-cutting, self-burning and overdosing. 'Woman A' proposes a different version of events. She includes under the umbrella of self-harm – 'worrying' and 'doing too much' – behaviour that most of us would see as falling well within the normal range. A question arises with regard to where a line might most usefully be drawn between the lapses and failures of self-care characteristic of 'normal' behaviour and actual self-harm. The process of writing a book on self-harm, including the task of selecting clinical examples for presentation, brought me face to face with this particular question.

Close examination of the existing literature led me to conclude that current descriptions of self-harm were inadequate in certain respects. In an endeavour to develop a more inclusive account, I enlisted the assistance of fellow practitioners, undertaking the research presented and discussed below.

THE VALUE OF DESCRIPTION

The rallying cry of phenomenology, the philosophy developed by Edmund Husserl (1859–1939), was 'To the things themselves' (*zu den Sachen selbst*). The aim was to *describe* our direct experience of the world and, through the process of 'bracketing off' assumptions (the law of *époché*), to avoid the distorting effects of theories and presuppositions. The validity of the concept of '*époché*' is challenged in postmodern writing, where it is argued that there is no 'neutral' position from which to take a perspective. These ideas have been influential in the field of psychoanalysis and few of us now believe that it is possible for assumptions to be 'bracketed off' and set to one side: 'It is especially important to emphasize that narrative is not an alternative to truth or reality; rather it is the mode in which, inevitably, truth and reality are presented. We have only versions of the true and the real' (Schafer 1992: xiv). In this paper I endeavour to present a descriptive version of 'the true and the real' in relation

to the subject of self-harm. I acknowledge that this is only one of many possible descriptions one that is necessarily informed by my own stance and position as well as by the phenomenon under investigation.

The primary task of psychodynamic theory and practice is to understand and elucidate the underlying meaning of experiences, symptoms and actions. The success of this endeavour is dependent upon an adequate level of description. That is to say that for our theories, and the practice informed by those theories, to be robust and well grounded, we need as a reference point a description that does justice to the complexity of the phenomenon in question. In addition, good description is in itself a source of containment, offering a secure base from which to work and a measure of protection against the tendency to sensationalize and stereotype self-harming behaviour characteristic of much of the popular literature on the subject.

Psychoanalysis has made valuable contributions to understanding the dynamics that drive self-harming behaviour. Gardner (2001) offers an excellent summary as well as extending psychoanalytic thinking, and I shall also return to the question of underlying meanings and of the impact of self-harming behaviour on the practitioner in future work (2002 forthcoming). In this paper, vital questions concerning the symbolic meaning and communicative value of self-harm are temporarily set aside so that precedence can be given to the task of arriving at a satisfactory description of the multi-faceted phenomenon of self-harm.

The aim is not to present a final and definitive account of the type described by Levinas (1961) as 'totalizing'. As is the case in clinical encounters with self-harm, the development of a descriptive account calls for a capacity to tolerate ambiguity, to suspend judgement and to bear with a state of uncertainty.

HIDDEN SELF-HARM

Many of us experience 'high visibility' self-harm – whether we witness it or hear it described – as shocking and upsetting. Maintaining a compassionate and ethical stance is by no means easy and we need to take seriously the particular issues raised by such dramatic and distressing behaviour. At the same time, it is important that our endeavours to make sense of self-harm should be grounded in the description and consideration of a representative range of examples.

A particular area of inadequacy in descriptions of self-harming behaviour concerns what I refer to as 'hidden' self-harm. There is an element of poetic licence in my use of the word 'hidden', for that which is entirely hidden is not available to be written or spoken about. More precise descriptions would be 'virtually hidden' or 'low visibility' or 'low-key' self-harm, and the word 'hidden' is used here as shorthand for these phrases. In some cases the self-harming behaviour in question falls within conventionally accepted parameters, involving for example self-cutting or self-hitting, but the actions are perpetrated only occasionally, only minor damage is inflicted and the behaviour is not disclosed. In other cases, the self-harm in question does not fit with prevailing stereotypes and, partly for this reason, it passes unnoticed, or is noticed but not recognized for what it is.

It is said that 90 per cent of an iceberg lies hidden beneath the surface of the water. My suggestion is that the same is broadly true of self-harm. Neither dramatic nor 'attention seeking', much self-harming behaviour lies hidden in murky and uncertain waters, out of sight, unrecognized and unacknowledged for long periods of time. Perhaps (as with an iceberg) 10 per cent of the phenomenon of self-harm is clearly visible, another 20 per cent is 'low visibility' – submerged but vaguely discernible – and the remaining 70 per cent is entirely hidden from view. Sometimes a change of circumstances leads to a degree of thawing as when, in the context of a good therapeutic relationship, the client begins to let go of frozen defences. Then that which was entirely hidden may move closer to the surface and its contours can begin to be traced and explored.

Like high-visibility self-harm, hidden self-harm may be directed towards the interior of the body, affecting the functioning of internal systems, or towards exterior of the body, where the consequence is injury rather than illness. Many incidents of self-harm are not actively perpetrated but involve instead 'self-harm by omission'. For example, clients may damage their health through failure to ensure adequate sleep or nutrition or failure to seek appropriate medical attention. Alternatively (or additionally), they may bring injury upon themselves through reckless behaviour or accidents arising from distraction or inattention. Practitioners who work in the community frequently encounter hidden self-harming behaviour, much of which is associated with lapses and lacunae in self-care rather than active self-directed violence. Such examples are, however, rarely referred to in the literature, where there is a strong focus on self-harm of a striking and immediately obvious, often dramatic, nature.

AIMS OF THE RESEARCH

A specific aim of my research was to assist with the selection of clinical examples for inclusion in a book focusing on hidden self-harm. I had already decided to include only examples where 70 per cent or more of practitioners felt, after reading and discussing the relevant clinical vignette, that the behaviour in question qualified as self-harm. A broader aim was to develop a descriptive account of self-harm that did justice to its multi-faceted nature. Through presenting alternative models of self-harming behaviour and introducing the concept of the 'casha' – culturally accepted self-harming act/activity – I aimed to open up the question: 'What do we mean by self-harm?' I hoped in this way to elicit feedback from the audience which would prove useful to the development of a better understanding of the subject of self-harm as a whole.

CLINICAL EXAMPLES FROM GROUP SUPERVISION

The first phase of the research involved the generation of clinical examples. Some clinical examples, which space prevents me from describing in detail in this paper, were taken from my own practice. I did not want to rely solely on my own experience and sought to generate additional examples based on the work of other practitioners. In pursuit of this aim, I asked three supervision groups which I convene on a regular basis to participate in the preliminary phase of the research by discussing the question: 'What do we mean by self-harm?' The following narrative was compiled using a version of grounded theory methodology (Glaser and Strauss 1967) from material that emerged over three supervision sessions, each of which involved between four and eight participants.

> One participant begins by saying, 'So far, I haven't had anyone come to me who harms herself'. I see a couple of others nod and murmur in assent. I comment that, while this may turn out to be the case, I wonder if we might discover that they have, after all, come across self-harming behaviour of one kind or another. There is a thoughtful silence, then Sheila, a general practice counsellor, begins to speak:
>
> I'm thinking about Ruth, a woman I'm seeing for twelve sessions at the surgery. She has a baby, about 10 months old I think. And she's 19, though to look at her you would take her for even younger. I've seen her four times and I really don't think she's coping. She looks terrible – so pale and thin, with huge dark circles under her eyes. And yesterday it was quite cold out, but she still wasn't wearing

a coat. She had to bring Leo, her little boy, with her because her Mum wasn't well and couldn't look after him. Leo obviously had an awful cold and was thoroughly miserable, snuffling and crying – really a poor little thing. They both looked utterly exhausted. I just wanted to give them a warm bath and tuck them up in bed.

Then Ruth told me, 'I'm pregnant again'. I felt absolutely dismayed. 'Oh', I said. I was trying to sound neutral but I'm sure my face told quite a different story. 'It's all right', she said. 'The new baby's Dad is a real smasher.' The choice of that word 'smasher' sent another jolt through me. One of the things Ruth has told me is that Leo's father was violent towards her and that's why she split up with him. So now I'm sitting here now wondering about this, her getting pregnant and planning to go ahead and have this second baby, when she's not coping with the first one. Would you see that as an example of self-harm?

Rather than responding directly, I invite the other members of the group to respond to what Sheila has said. Like Sheila, they are upset by the story they have heard. They empathize with her sense of dismay and helplessness. Most of them say that this is self-harm, just as surely as deliberately cutting your arm is self-harm, but two group members are unsure about this. It seems to them 'too different'.

The next contributor, Lynn, tells us about a client, Bernie.

> Bernie is very attached to his running schedule. I don't see anything wrong with this. I don't run myself but I like to do a lot of walking and, on the whole, I think that exercise is beneficial, emotionally as well as physically. But I was very concerned about what Bernie told me last week. He has been in bed for two days with a bout of 'flu and had a high fever. In fact, I knew this because he had rung me to cancel a session. The next day, he went out running in the park, aiming to do an extra long run to make up for lost time. Along the way, he virtually collapsed. After sitting on a park bench for a while, he was able to use his mobile phone to call a taxi to take him home.

Lynn says that she is wondering now whether Bernie's behaviour should be seen as a kind of self-harm. She notes that, in punishing himself for what he perceives as his weakness, he has set back his recovery and made himself feel very unwell again. She asks the group what they think. This time, opinion is more evenly divided. A number of people say that the story makes them feel anxious about Bernie. He could have brought a heart attack upon himself. He could have caught pneumonia. He could have died. Others say that it's normal, after all, to push yourself to achieve your best and that people do make mistakes and then find that they have gone beyond their personal limits.

Jane tells the group about a man in his fifties whom she has been seeing in the context of her work as a bereavement counsellor. (Later, as part of her MA submission, she writes an essay about this client

and his 'accident proneness', which she also makes available to me.) 'Harry' has a history of falls, injuries, illnesses and frequent childhood hospital admissions 'too numerous to mention'. During eighteen months of therapy, he has cut himself twice, burned himself while cooking, sustained a scald, painfully stubbed his toes six times, trapped his fingers and cut himself by accidentally breaking an ornament that belonged to his mother.

The past is marked by four life-threatening 'accidents' which have left him a chronic invalid, having to walk on sticks and practically housebound. The first of these was a very serious car accident at age 19, in which a girl was killed. It happened shortly after the end of Harry's first sexual relationship, which Harry accused his mother of 'deliberately trying to sabotage'. Twelve years later, working as an engineer in a job his father had found for him, Harry electrocuted himself. Just before this, he saw his father's contemptuous face, thought 'I shouldn't do it' and then connected the wrong wires. At 43, Harry fell from his bike into the path of a lorry and broke several bones. Finally, eight years ago, he fell from a ladder that he knew had 'rotten rungs' and sustained a back injury 'that still gives him gip'. At the time he had been depressed, not caring what happened to him.

The final person to speak is Rachel and she chooses to speak about herself. She finds, she says, that she is working 'flat out' and that the discussion has made her realize how little care she is taking of herself. She used to go to a yoga class, have an occasional massage or even an early night but now she never does. The reason is that her job with a voluntary organization has become ever more demanding. As well as her clinical work, Rachel is putting in many extra hours trying to safeguard the future of the organization, lobbying the local authority for continuation of funding and bidding for grants from other sources. She also has primary responsibility for two teenage children. She says that she feels exhausted, sleeps fitfully and suffers from high blood pressure. In a dream, she visited her GP who told her she had, at the most, five years to live. She awoke in some distress thinking of her children and the loss and pain they would suffer, then found herself reflecting that dying would be something of a relief.

On the basis of these contributions, four vignettes were written summarizing the situation with 'Ruth' and 'Bernie' and 'Harry' and 'Rachel'. Each of these was used alongside the vignettes of 'Sarah', 'Ellen May', 'Peter' and 'Kate', taken from my own practice, in the second phase of the research.

'QUALITATIVE LEAP' AND 'CONTINUUM' MODELS OF SELF-HARM

The second phase of the research involved presentation of the vignettes at four separate conference/research group venues. Most

of the participants involved in this phase were counsellors or psychotherapists. In each case, a small number of other health service professionals were also present. Each session began with a presentation describing two models of self-harm and introducing the idea of a 'casha' (Culturally accepted self-harming act/activity). Following the presentation, participants were asked to consider and comment on vignettes involving actions, or failures to act that might or might not be seen as examples of self-harm. A count was made on the basis of a show of hands of those who would see a particular vignette as describing self-harm and those who would see it as describing a collection of 'cashas' and percentages were calculated.

I began each presentation by suggesting that the current definition of self-harm is relatively narrow, in the sense that it is used primarily in relation to severe and highly visible examples of self-harming behaviour. According to this understanding, only a small minority of individuals harm themselves and their behaviour is in a category of its own, in no way akin to 'normal' behaviour. I described this as the 'qualitative leap' model of self-harm, since the behaviour of individuals who self-harm is seen as qualitatively different from that of 'normal' individuals (Figure 1).

Figure 1 depicts a commonly held view of self-harm. Self-harm belongs in a discrete category of its own, a world away from ordinary, good-enough self-care. There is no gradation, no 'in between' position. This model both reflects and underpins the situation reported by clients in counselling or psychotherapy who have disclosed self-harm in other contexts. They feel they have been seen as entirely different from 'normal' people. In some cases this 'difference' has been underlined by the attribution of a psychiatric diagnosis such as 'borderline personality disorder' or 'multi-impulsive personality disorder'. Many individuals who self-harm have described being ostracized, stigmatized, not comprehended or dismissed as 'crazy', or 'attention-seeking' by professionals from whom they have sought treatment.

It seems that such complaints represent more than the voice of the disaffected few. Many counsellors who took part in the research told me that such incidents had been described to them by clients whom they believed to be trustworthy. The Bristol Survey (Arnold 1995) received many similar reports, and punitive treatment or refusal to treat injuries is frequently reported to the National Self-Harm Network (Pembroke 2000: 5). Clients whose self-harm has previously been hidden and is revealed once a therapeutic relationship has been established commonly cite a fear of being disapproved

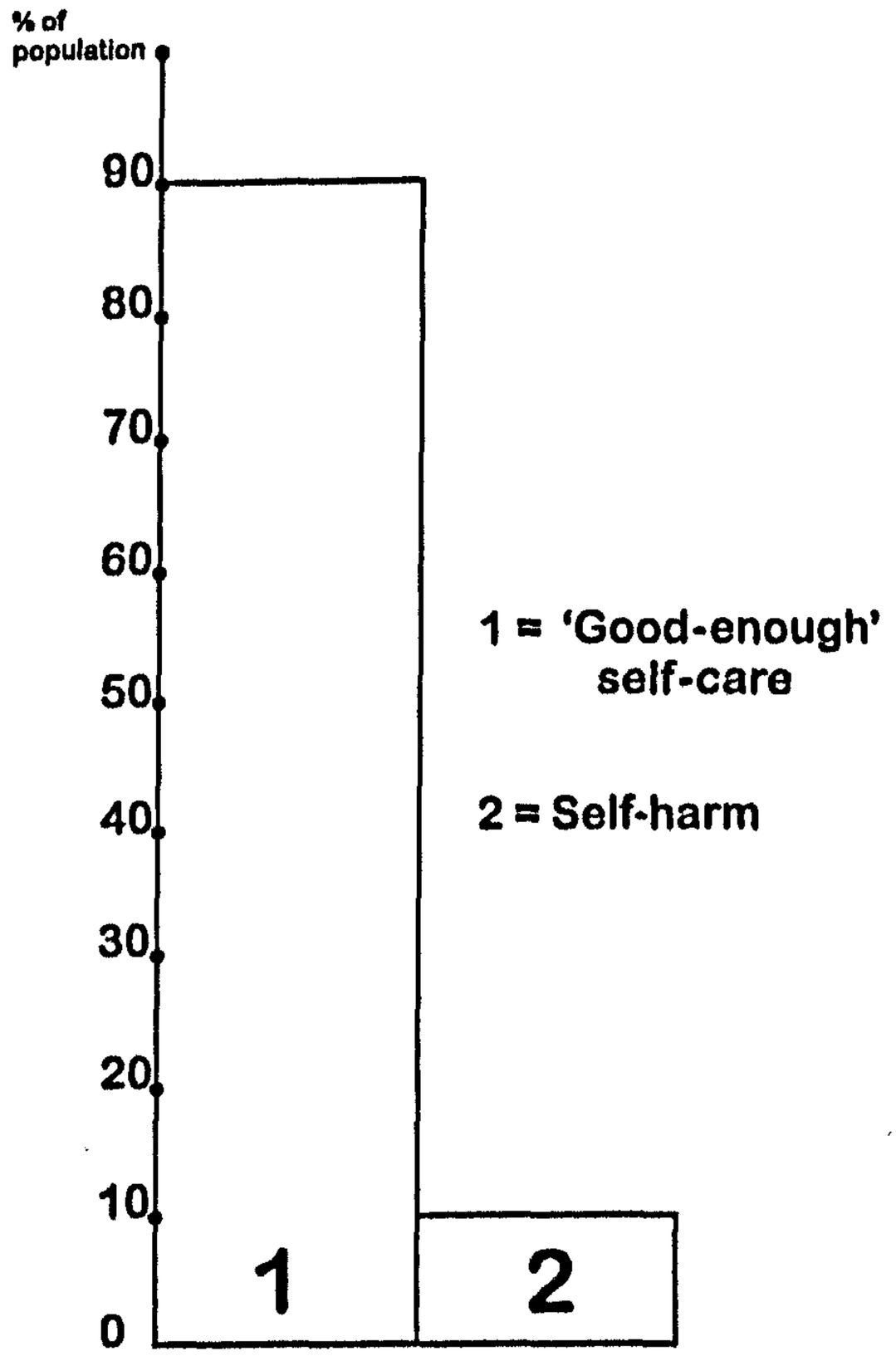

Figure 1 'Qualitative leap' model of self-harm

of and thought 'crazy' as a reason for previous non-disclosure. The presentation continued with the introduction of the 'continuum' model of self-harm (Figure 2).

In contrast to the 'qualitative leap' model, the 'continuum' model of self-harm suggests a gradation from 'good-enough self-care' to 'compromised self-care' to 'mild self-harm' to 'moderate self-harm' and, finally, to 'severe self-harm'. (The percentages given in the charts are indicative only. As there are no relevant statistics available, estimated figures based on clinical experience have been used.) There is a clear link between self-harm and 'normal' behaviour. An 'in-between' area comes into view which both connects and separates the two. At each of the research events, the idea of a self-harm–self-care

Figure 2 'Continuum' model of self-harm

continuum was greeted with considerable enthusiasm. Many practitioners expressed strong support for this perspective, echoing and expanding upon my desire to create a conceptual space in which to discuss behaviour which gestures towards self-harming tendencies but falls outside current stereotypes of self-harm.

CULTURALLY ACCEPTED SELF-HARMING ACTS/ACTIVITIES ('CASHAS')

Before moving on to consideration of clinical vignettes, the idea of the 'casha' was introduced to the audience. This idea builds on the work of cultural psychiatrist Armando Favazza (1989a, 1989b), who

was one of the first people to attempt a comprehensive exploration of self-harming behaviour and whose writing has played an important role in legitimizing the study of self-harm. Challenging a number of prevailing stereotypes, Favazza insisted that the behaviour should not be trivialized as 'attention seeking', misidentified as a suicide attempt or regarded merely as a symptom of borderline personality disorder. In addition, he drew attention to culturally accepted forms of self-harming behaviour that can be observed in every part of the world.

I have coined an acronym for such behaviours, referring to them collectively as 'cashas'. In some cases, 'cashas' have a specific role and meaning, serving as a rite of passage or signifying identification with a particular tribe or sub-culture. Body-piercing in the context of the UK youth sub-culture would perhaps be a case in point. In some instances, they are associated with religious practices, as, for example, with self-flagellation or pilgrimages that involve covering long distances over stony ground barefoot or on bended knee. Favazza's work offers an extensive and fascinating account of such phenomena.

The 'cashas' that are of most interest with regard to the question of where we draw the line between normal, flawed, self-care and actual self-harm fall into a third category. They are the everyday, low-key activities and behaviours which are nevertheless associated with injury or ill-health. Smoking offers an obvious example. Its physically harmful consequences are well documented but smoking is not generally seen as an example of self-harm. To take another example, chronic overwork is associated with 'stress', which has been shown to play a part in many mental and physical health problems. A few years ago, the Japanese, perhaps taking matters to their logical conclusion, created a new term – '*karoshi*' – meaning 'death by overwork'. It came into the language after a 38-year-old accountant worked without a break for fourteen days then died the next night in his sleep (Denny 1998). Nevertheless, for the most part, almost any degree of overworking remains culturally acceptable, in the UK as well as in Japan.

The situation is complex since it seems that a 'casha' can shade almost imperceptibly into self-harm. I have in mind, for example, behaviour such as heavy smoking where there is an existing smoking-related health problem or continuing to work at full throttle when illness has already been diagnosed. At some point, the behaviour is experienced by those witnessing it as transgressive, as having moved beyond the border area of the 'casha' and into the domain of self-harm proper. This point varies between cultures and between generations, hence behaviours that attract the self-harm label *always*

combine an element of self-inflicted illness or injury with an element of transgression, with the breaking of unspoken cultural rules. This element of transgression is particularly important, being inherently meaningful. It tells us that the person concerned is unable, or perhaps unwilling, to manage his or her psychological needs without recourse to socially proscribed action or inaction. Such breaching of the limits in itself speaks of a heightened state of distress, of a certain level of desperation.

DISCUSSION OF CLINICAL VIGNETTES

At the end of the presentation, participants were invited to ask questions and make comments. Then typescripts of two vignettes were distributed to those present. An example of one of the vignettes, based on my own work, is given below:

Sarah's story

About three months into our work together, Sarah tells me about a period of her life, shortly after she finished university, when she became extremely depressed and retreated from the world. She did not seek work and became more and more isolated as, one by one, her friends left the university town. She made no contact with her family, who lived over a hundred miles away.

Sarah describes various symptoms that she experienced at that time – a buzzing sound in her head, a feeling of being cut off and unreal and an all-encompassing 'mental blankness'. Sarah also developed very bad eczema. We talk about this and share an understanding that this symptom represented some kind of eruption into the outside world of a very disturbed inner state. There is a tense silence as Sarah struggles to tell me the next part of her story. Then she describes how she neglected her eczema to the point where she developed secondary infections and her body was covered in sores. It was difficult to move around. Dressing and undressing were acutely painful, as her clothes would repeatedly adhere to her weeping skin.

I feel dismayed when Sarah tells me that she remained in this state for more than six months. Finally, at Christmas, she went home to her family. Her mother quickly became aware of the state of her skin and 'marched her off' to the local doctor. The doctor was profoundly shocked and shouted at Sarah in the surgery. Subsequently, he apologized, adding that it was the worst case of eczema and skin infection that he had ever seen.

I ask Sarah what help she was offered and she tells me that the doctor prescribed antibiotics and steroid creams. There was no suggestion of counselling or any other kind of psychological help.

Other vignettes were of a similar length and style. Participants were given fifteen minutes to read each vignette, discuss it in a small group and consider their response to the question: 'Is this an example of self-harm?' Counting was done on the basis of a show of hands. The results are given below.

Name	*Behaviour in question*	*Percentage regarding behaviour as self-harm*
Ellen May (my client, not described here)	Anorexia and bulimia including damage to throat	100
Sarah (my client, vignette above)	Neglected eczema and skin infection	95
Harry (vignette from supervision group)	'Invited' accidents, both major and minor, leading to chronic illness and disability	90
Peter (my client, not described here)	Frequent minor accidents, sexual risk-taking, hidden drug and alcohol abuse	80
Kate (my client, not described here)	Overriding of physical symptoms, leading to aggravation of RSI and permanent disability	75
Ruth (vignette from supervision group)	Failures of self-care, leading to second unwanted pregnancy	60
Bernie (vignette from supervision group)	Inappropriate and excessive use of exercise	50
Rachel (vignette from supervision group)	Overworking. sleep disturbance, exhaustion, high blood pressure	50

During the discussions that followed, a number of interesting themes emerged. It became clear that the question of 'severity' is a complicated one. For some practitioners, the intention behind the action was the most important consideration, while others were more swayed by the level of the physical damage itself or by the 'shock value' of the behaviour. Practitioners who felt that a certain example

did not qualify as self-harm were invited to comment on their decision. The reasons given fell into two main categories. The first was that the behaviour in question was 'passive' rather than 'active'. This comment was made, for example, by all three of the seventy practitioners who did not see 'Sarah's' behaviour as an example of self-harm. The second was that the behaviour in question was so common and generally accepted that one could not see it as self-harm This was said most often in relation to the vignettes describing 'Bernie', 'Ruth' and 'Rachel'.

These exchanges caused me to move away from the terms 'mild', 'moderate' and 'severe' self-harm and towards the terms 'hidden', 'low-visibility' and 'high-visibility' self-harm, a change that is reflected in this paper. They also brought into view the fine detail of the border area that divides a 'casha' from an act of self-harm. At some point, behaviour crosses this border and moves into the terrain of self-harm proper. The point at which this happens is elusive. It is clear that the judgement that an action does or does not qualify as self-harm is influenced both by the cultural context within which the act is embedded and by individual subjective factors. Thus it is impossible to identify and describe what is and what is not self-harm without reference to this element of transgression of norms.

SELF-HARM STEREOTYPES

Some discussions of self-harming behaviour are characterized by a high level of stereotyping. One example is the regular use of terminology with marked negative connotations in association with self-harming behaviour. Across a range of professions, clients who harm themselves are presumed (at least until proven otherwise) to be 'provocative', 'angry' and 'disruptive'. Among nurses, patients who self-harm are routinely referred to as 'attention seeking'.

The use of such language offers a rationale for unsympathetic or even punitive behaviour. During a conference on self-harm, a mental health nurse in my group spoke about a patient who cuts herself on the ward. 'If she does that, I tell her "You can get the mop and bucket and fucking well clear it up yourself!"' In the Bristol Survey, women repeatedly referred to unsympathetic treatment, having cuts sutured without anaesthetic, being placed last in line at Accident and Emergency, being refused the 'talking therapies' they asked for, being told by psychologists to go away and come back when they have stopped harming themselves (Arnold 1995). Dawn Collins

comments that in 'the medical model, where the injury is regarded as the symptom, the self-harmer often becomes re-abused in a system that fails to see the injury as a communication of the trauma, but views it instead as manipulative' (1996: 464).

In similar vein, Gardner notes that:

> There is a tendency in some settings for clinicians – as one way of coping with the patient's behaviour and the unwelcome effect upon themselves – to use alternative descriptive labels such as 'cutter', 'slasher' or 'scratcher', often alongside the defensive reasoning that all such behaviour is merely 'attention seeking'.
>
> (Gardner 2001: 9)

A more sympathetic form of stereotyping identifies the self-harming client as the victim of sexual abuse. But by no means everybody who self-harms *has* been sexually abused. In a survey of seventy-six women undertaken by the Bristol Crisis Service for Women, 49 per cent of the respondents – just under half – responded positively to questions relating to sexual abuse. In Gardner's sample of fifteen young women whose deliberate self-harm led to referral, only four had been sexually abused (2001: 18).

In fact, individuals give many different reasons for harming themselves. In the Bristol Survey, neglect, echoed in the phenomenon of self-harm by omission referred to above, was mentioned in 49 per cent of cases. Emotional abuse was mentioned in 43 per cent of cases and lack of communication in 27 per cent of cases. In Gardner's sample, young female clients referred to separation and divorce, mother leaving home, being sent to boarding school and feeling under great pressure to be successful as precipitating factors. My own experience also attests to an enormous variety of perceived causes of self-harm. In addition to some of the experiences listed above, clients have identified bullying, racial abuse and having a mother who was narcissistically preoccupied as factors contributing towards their self-harming behaviour.

These descriptions by no means support the common assumption that self-harm is specifically associated with childhood sexual abuse, and the prevalence of this stereotype is a cause for concern. Recently, I received a telephone call from a counsellor I did not know. She told me she had been referred a client who harmed herself and added, 'I suppose that means that she has been sexually abused'. I felt it important to emphasize in as helpful a way as possible that the meaning of self-harming behaviour cannot be catalogued in this way. It remains to be discovered anew in each individual encounter between a client and a practitioner.

As noted above, a diagnostic label is frequently applied to clients whose self-harm brings them into contact with mental health services. It is not uncommon for a 'borderline personality disorder' diagnosis to be made on the basis of self-harming behaviour alone, although, in terms of the formal criteria, this is a misuse of the diagnostic term. Some practitioners – a handful of psychiatrists and a much larger number of psychotherapists – have argued that psychiatric labelling of any kind may do more harm than good (for example, Goffman 1959; Laing 1960; Szasz 1961; Giovacchini 1993; Turp 2001). Tantam and Whittaker (1992) raise particular objections to the use of 'personality disorder' diagnoses in cases of self-harm: 'The attribution of upsetting behaviour to abnormal personality tends to blunt the normal caring response. . . . Too often, further inquiry into the reasons for the behaviour, in particular into the situational determinants of self-wounding, stops once a diagnosis is made'.

A key theme in psychodynamic thinking is the relationship between stereotypic explanations and premature closure. We are aware of the way in which an assumption of a general kind of knowing may relieve the emotional discomfort of the practitioner, offering a form of words to cover the situation and removing the need to engage with what is going on at a deeper level. When the specifics of the situation and the individual's personal and unique experience are glossed over, stereotyping stands in the way of any genuinely therapeutic intervention.

Poor practitioner containment increases the likelihood both of retaliatory responses and of stereotyping: 'Unless we are well supported in our work, we will tend to defend ourselves against the levels of distress involved and such defensiveness will inevitably interfere with our ability to remain thoughtful in the face of self-harming behaviour' (Turp 1999: 310).

Education and understanding are also sources of containment (Bion 1967a) and here detailed description and the deconstruction of self-harm stereotypes has a part to play. Clients like 'Sarah', 'Ruth' and 'Bernie' can hardly be described as 'attention seeking'. In some cases, they have failed to recognize their own behaviour as self-harm. In others, they have done their best to hide their self-harm from the external world. There is nothing here to indicate a 'personality disorder' diagnosis. It is also the case that, according to their own accounts, none of these three clients has been sexually abused.

Clinical experience and research combine to suggest that there is no single explanation for self-harm, no single meaning or commu-

nication conveyed by self-harm, no single psychological disorder or personality profile associated with self-harm. Our best beginning is to accept not to know and to engage with the situation 'without memory or desire' (Bion 1967b). In this way, the specifics of the story and the meanings of the behaviour may in time emerge and begin to make sense in the mind of both the practitioner and the client.

THE 'CASHA' AND THE PRACTITIONER

'Cashas' are complex phenomena, varying between cultures and even sub-cultures. In Western Europe and North America, for example, we tolerate smoking (except perhaps in California). We accept participation in high-risk sports and activities such as mountaineering. As a culture we applaud overworking and ignore its deleterious effect on mental and physical health. Many people in my own age group draw the line at body-piercing and tongue-splitting (where the tongue is cut and stitched so as to have a 'forked' appearance). However, such acts are perfectly acceptable within certain youth sub-cultures.

A key point is that in every society, apparently by common consent, certain outlets are made available, certain behaviours are sanctioned in spite of their potential to lead to injury or to result in internal self-harm. In this, there is perhaps an unconscious acknowledgement of the destructive and self-destructive tendencies, eloquently described by Melanie Klein, that reside within each of us alongside more creative tendencies. For as long as we confine ourselves to the permitted outlets, we will not be perceived as perpetrating acts of self-harm. The key issue, then, is that of transgression. The line drawn is not arbitrary but it is culturally relative and is not directly related to the health risks involved in a particular action or activity. In introducing the idea of a 'casha', a category of behaviour is identified that acts as a bridge between self-care and self-harm. The 'casha', falling as it does within the limits of permitted failures of self-care, is seen as 'normal', while self-harm, which transgresses those limits, is seen as abnormal and often provokes a negative reaction.

'SALLY' AND 'JANET'

The interaction described below indicates that thinking in terms of a broader description of self-harm is a matter of more than purely

academic interest. It invites the possibility of seeing clients who harm themselves as less 'other' and 'alien', as rather more like ourselves. There is an opportunity for the counsellor to identify in some way with the client and her pathology. This in turn enhances empathy and sets the scene for the emergence of a viable therapeutic alliance. The final case example revolves around this theme. A counsellor brings to supervision a client 'Sally', who has referred to a dilemma with a familiar feel.

> At her second session, Sally reveals that she has intentionally cut herself. In response to Janet's enquiry, she says that she has done the same thing before, but not for over a year. She describes how this time she felt compelled towards self-cutting and yet tried to resist the compulsion. Her eyes kept being drawn to the kitchen drawer. Eventually she took out a sharp vegetable knife that she knew was there. She replaced it, then took it out again. She 'hid' it, went out and bought a pint of milk. But when she returned, she retrieved the knife and cut herself on her arm.
>
> Sally says that she had 'kind of gained control over the situation' but had then allowed herself the self-injury. She tells Janet, 'I knew I was on the edge. It was the only way to be sure that I wouldn't start hitting the kids and screaming at them five minutes after they got in from school. I wanted us to have a nice evening.' Janet keeps her outward response neutral and plays for time, saying that this is clearly a subject that will need careful consideration.

In supervision, Janet wonders whether Sally is a suitable client for the kind of counselling she offers – psychodynamic counselling on a once weekly basis. She feels she might find it too difficult to work with Sally, that Sally is perhaps too 'disturbed'. I bring into the supervision session the Kleinian concept of projective identification (1946), reminding Sally that the feelings being unconsciously stirred up within her by the client are there to be thought about and are likely to emerge as meaningful in the longer term. Janet identifies her primary emotional response as fear and begins to wonder whether Sally herself has felt very afraid in the past and, if so, what has been so frightening for her.

We note that Sally has made an early reference to difficulties in managing anger, speaking of a fear of 'hitting' and 'screaming at' her children. We identify a need both to keep the underlying anger in mind and, at the same time, for Janet to work in a sensitive way. Inevitably, the meanings of Janet's communications will be coloured by Sally's past experiences and we are aware that many individuals who harm themselves have at some point been 'accused' of being angry, manipulative or provocative. In this supervision session, I take the Bristol Survey off my shelf and quote to Janet an experience described by one of the respondents: 'I saw a psychiatrist who just said: "You're too angry to treat, psychiatry can't help you"' (Woman E, Arnold 1995: 19).

As we talk further, Janet brings into the conversation her current endeavour to give up smoking. Apparently, this sometimes involves taking out a cigarette and replacing it several times, 'hiding' the packet and distracting herself by going for a walk or to buy some shopping. Janet is making progress but still 'gives in' to a cigarette from time to time, particularly when she is feeling angry or upset.

These two developments – reflecting on the potential meaning of her counter transference responses, and recognising parallels with her own behaviour – are directly helpful to Janet, and indirectly helpful to Sally. Janet now feels fairly confident about working with this troubled client and hopeful about the possibility of establishing a good therapeutic alliance. In her next session with Sally, she comments on the high priority Sally places on being a good parent. Referring back to the self-cutting incident, Janet reflects that, at that time, cutting herself had felt like the only way for Sally to calm herself down and be the kind of mother she wanted to be. Sally is clearly moved by Janet's comment and becomes tearful.

Subsequently, Sally seems more trusting of Janet. Her responses are less guarded and Sally's feeling of wariness ebbs away. These changes find physical expression at the end of one particular session when Sally says that her cut is healing well and pulls up her sleeve to show Janet the dressing. The counselling continues for a further year (this being the time limit at the voluntary organization where Janet works). Sally cuts her arm once more during this time. In her sessions, she is able to talk about being physically abused by her father, who tied her up and beat her. Janet helps her to name and describe her terrible feelings of fear, rage and humiliation. Sally uses the time extremely well and makes a number of significant changes in her life.

In this example, Sally's counsellor allows herself to recognize the similarities between her own behaviour and her client's. In this context her client's self-cutting seems less shocking and the counsellor is able to maintain a therapeutic presence. Recognizing similarities and overlaps between self-harm and 'normal' behaviour sets the scene for a more compassionate stance. We have the opportunity to see self-harming clients as occupying a different position on a continuum rather than as inhabiting a separate and qualitatively different terrain.

DESCRIBING AND DEFINING SELF-HARM

I hope it is clear from all that has gone before that defining self-harm is not an exact science. There are choices to be made about where various lines might best be drawn. The definition of self-harm given below is based on the research and reflections described above.

It is a part of work in progress to which I hope others will contribute and is not intended as any kind of final word.

Self-harm is an umbrella term for behaviour:

1. that results, whether by commission or omission, in avoidable physical harm to self and
2. that falls outside the limits of culturally accepted self-harming activities applying at the place and time of enactment.

Criterion 1 encompasses both external and internal self-harm. It refers to self-harm that results from both active and passive behaviour (self-harm by omission). Eating disorders and alcohol and substance abuse are encompassed by definition as special instances of internal self-harm, although they retain important distinctive characteristics of their own.

Criterion 2 involves making reference to the response, or imagined response, of individuals exposed to the behaviour concerned or to a description of that behaviour. While a 'casha' may provoke mild disapproval or concern, actual self-harm stirs up more disquieting emotions – for example, sadness, dismay, alarm, horror, guilt, anger or disgust – in many individuals. This part of the definition involves consideration of subjective responses to the behaviour in question. Such responses are culturally embedded, varying between times and places as well as between individuals. Thus, the many faces of self-harm are to some degree also the changing faces of self-harm. In this situation of shifting sands, a stance of interest and ongoing curiosity is likely to be of greater value than any attempt to achieve final closure.

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Maggie Turp, Psychoanalytic psychotherapist in private practice,
73 Torbay Road, London NW6 7DU
Correspondence is invited. Please contact MaggieTurp@aol.com

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PART 3

3.1: THE WORK IN CONTEXT

The work derives from and resides within an object relations framework. In earlier papers and the first book, the primary emphasis is on Winnicott's thinking, which is adopted as the starting point for the development of an explicitly holistic psychoanalytic perspective on psychosomatic disturbance. Winnicott's writing on 'the indwelling of the psyche in the soma' (1970) and his designation of psychosomatic illness as a bid for recovery as well as a mode of psychic survival is of key importance.

In later work Kleinian and post-Kleinian perspectives come to the fore. The shift of emphasis follows in part from my continuing involvement in psychoanalytic infant observation. Also relevant is the focus in later work on self-harming behaviour. Kleinian theory, in particular the close attention paid to destructive and self-destructive tendencies, offers a highly relevant theoretical context for discussion of clinical work with clients who self-harm, many of whom reveal themselves as '... acutely at the mercy of impulsive fluctuations which can swamp the mind with anxieties, rages and passions' (Likierman 2001: 2).

A more extended framework consists of the body of psychoanalytic literature as a whole. Larger scale psychoanalytic studies are cited where available and relevant, for example Spitz (1945), Hopkins (1990), Robertson (1953). Reference is made to controversies within psychoanalysis and historical developments in psychoanalytic perspectives on the mind/body question (Turp 1999b, 2001 ch.5).

The body and the relationship between mental and physical dimensions of functioning are subjects of interest, in some cases of central interest, to many disciplines, including medicine, neuroscience, philosophy, sociology, psychology and cultural studies. Reference is made in the submitted work to a number of relevant developments in philosophy, social and cultural studies, psychology (particularly developmental and health psychology), physiology and neuroscience and I affirm an interest in pursuing 'possibilities for mutual gain' (Olds and Cooper 1997) between psychoanalysis and other disciplines (Turp 2001:57). The quantity and variety of material which touches upon 'the physicality of the self' and my relative unfamiliarity with research in other disciplines are acknowledged as limiting factors.

With regard to philosophy, the model of mind/body dualism advanced by Rene Descartes (1596 – 1650) is identified as the foundation for assumptions inherent in the Western medical model of health and illness (Turp 2000c, 2001, ch.3, ch.4). This model is compared and contrasted with alternative conceptualisations of human

functioning, in particular those associated with phenomenology and postmodernism. I refer to different philosophical perspectives on 'mind' and 'body', including Eastern philosophies, noting that in some cases underlying beliefs and assumptions may bear little resemblance to those with which we are familiar in our own culture (Turp 2001:40-41). Turp 2000c argues that dualistic conceptions of the human subject are simplistic and inadequate and the continuing prevalence of dualistic assumptions in contemporary Western thought and in institutions such as the NHS regularly resurfaces in the submitted work as an area of concern.

Phenomenological and postmodern perspectives and points of contact and tensions between them form an important backdrop to the work, not least because they provided a context for the development of non-dualistic perspectives on the human subject which are compatible with Western belief systems. The postmodern critique of the scientific method and scientific claims to universal truth is discussed with particular reference to the medical model and examples are given of clashes between medical experts operating from a traditional perspective and clients embracing a holistic perspective. The challenge presented to traditional doctor-patient relationships by the availability of detailed medical information on the internet is noted (Turp 2001:38).

The aspect of post-modern thought that relates to its '... rejection of both the idea that there can be an ultimate truth and of structuralism' (Burr 1995, cited in Turp 2001:36) is recognised as relevant to the psychoanalytic endeavour. I express support for the view that all perception and experience involves interpretation and describe theory as 'no more, and no less, than a valuable tool for thinking' (Turp 2003:73), a point of view which has gained ground over recent years but remains controversial. One of several authors cited in this discussion (Turp 1998, 2001) is the American psychoanalyst, Roy Schafer:

> It is especially important to emphasize that narrative is not an alternative to truth or reality; rather it is the mode in which, inevitably, truth and reality are presented. We have only versions of the true and the real (Schafer 1992 cited in Turp 2001:6).

I find considerable merit in Schafer's position, which embraces the idea that experience is largely socially constructed while at the same time reserving a special place for the individual colouring of that experience.

Contemporary developments reflecting changes in lifestyles and attitudes, for example the popularity of complementary medicine and the rise of the 'health club', have an immediate relevance to the work. In one sense, the whole project can be seen an

expression of significant social trends, including dissatisfaction with the traditional medical model, a desire to take control of one's own health and a concern with individual self-expression and personal meaning. The exercise activities referred to by myself and my clients, for example yoga, fitness training, Alexander Technique, Tai Chi, swimming and running, reflect the current decline of team sports and increasing popularity of individualised exercise. Hollway (1996) has characterised the search for personal meaning as a pathway to health, a position which implicitly underpins our activities as psychoanalytic practitioners and our clients' belief in the possibility of being helped by coming to talk to us. The increasing importance of the work ethic in the United Kingdom is identified as another contemporary issue with complex social meanings and legal ramifications and is discussed as a potential example of a 'casha' (culturally accepted self-harming act/activity) (Turp 2003:10).

In Turp 2001, Part 1, the question of what we might mean by health and the issue of 'perfectibility' is discussed with reference to the definition set out by the World Health Authority (1948), phenomenological perspectives and work by Adam Phillips (1999). These themes are revisited in Turp 2003, in the context of the risk of a concern for self-care becoming 'disciplinary' (Foucault 1970, 1984) and the discussion of tensions between emotional and physical self-care (Turp 2003:33-35). Turp 2003 also introduces a discussion of social and cultural dimensions of 'body storylines', with particular reference to the concept of 'habitas' (Bourdieu 1977, 1987, cited Turp 2003:120, 204).

In the last two decades, there has been an upsurge of interest in the social and cultural analysis of body-centred experiences and behaviours. A number of examples are referred to in Turp 1997, 1998 and 2001. Themes addressed in publications in the journal 'Body and Society' testify to overlapping areas of interest between psychoanalytic and sociological investigations in this area. For example, the subject of cosmetic surgery is of relevance to my suggested distinction between 'lived body' – the body as experienced from within – and 'body as object', '... to be perfected, sculpted, deprived, obsessed over, injured, ignored, neglected or narcissistically worshipped' (Turp 2001, p.27). Addressing the issue of cosmetic surgery from a sociological perspective, Negrin refers to '... the instrumentalization of the body as mere matter' (2002: 84). Davis, in a discussion of the growing popularity of cosmetic surgery among men, refers to 'a dubious equality' (2002: 49) and Budgeon (2003) discusses the implications of the mind/body split from a feminist perspective.

Reference is made in the submitted work to developmental psychology, health psychology and exercise psychology. The work of the Stern (1977, 1985), Trevarthen

(1979), Brazelton (1982) and Barnard and Brazelton (1990) is identified as being of particular interest and a source of methodological triangulation of psychoanalytic infant observation findings. Reference is made also to research in the fields of dance studies and physiology (Turp 1999c, 2001), which illuminate the particular qualities that characterise and link experiences of movement and touch and the 'sixth sense' of proprioception (Turp 2000a, 2001:113-115).

Developments in neuroscience, including the work of Damasio (1994, 1999), Schore (1997, 2001) and Pally (2001) are described (Turp 2003:197-202) and identified as a source of corroboration and refinement of psychoanalytic understandings. In Turp 2001, Part 1, developments in science, marked by a shift away from linear cause-effect relationships to the more complex and less predictable relationships envisaged in 'chaos theory' (Marshall and Dohar 1997) are considered. In Turp 2003, the relationship between natural science and psychoanalysis is discussed and cautious optimism expressed with regard to the dialogue opening up between psychoanalysis and the biological sciences (Turp 2003:199).

3.2 - THEORETICAL AND CLINICAL CONTRIBUTIONS

While continuing to reside within the mainstream of contemporary Object Relations theory and practice, the work extends theory and contains suggestions for shifts of focus in clinical practice. Some of the subject areas raised for discussion have previously been little explored from a psychoanalytic point of view. These include client descriptions of engagement with leisure exercise, the emotional and relational significance for a child of becoming mobile and the evolution of a capacity for self-care.

Existing theoretical descriptions are brought into new conjunctions, both with each other and with matters arising in the context of therapeutic discourse and/or infant observation. For example, the subject area of self-harm is discussed from a new vantage point, bringing to bear Winnicott's perspective on indwelling and post-Kleinian theory relating to damaged psychic skin functioning. In keeping with the strong clinical focus of the work, theoretical innovations are consistently discussed with reference to their implications for practice and detailed examples are given.

In view of the organic nature of the evolution of the body of work and the numerous points of contact and intertwining between the themes addressed, areas of development are not entirely distinct. Whilst presenting difficulties in terms of the Critical Appraisal document, this is seen as a valuable aspect of the work itself, contributing to its substance, reliability and overall coherence. Key areas of theoretical and clinical innovation are discussed below.

I Critique of psychoanalytic focus on pathology

As noted by Rycroft (1991), a focus on pathology is characteristic of the psychoanalytic project. 'Health' and 'normality' are alluded to by implication but are seldom the explicit focus of enquiry. Close attention to the detail of pathological states is appropriate in view of the ameliorative aim of the psychotherapy and, more specifically, the extension of clinical work in recent years to include psychotherapy with psychotic, borderline and autistic spectrum adults and children. At the same time, according to the arguments put forward in submitted work, an exclusive focus on pathology can lead to certain behaviours being misinterpreted or overlooked.

For example, in discussions with other psychoanalytic practitioners, I have often encountered a suspicious attitude towards vigorous physical exercise. Further enquiry has revealed an underlying assumption that elective exercise is an example of 'acting out' or an expression of self-punitive or narcissistic tendencies. That this may indeed be the case is not in question; nevertheless these are by no means the only possibilities. In my work, I argue for the body to be recognised as a site for creative self-expression and emotional recovery, as well as for the expression of pathology and distress (Turp 1997, 1999b, 2000a, 2000b, 2001, 2003).

In support of this argument, I present examples of physical exercise, such as running and Tai Chi, and touch experiences, such as massage and swimming, coming into the service of psychological recovery, in part through the evocation of 'memories in feeling' (Klein 1957 cited in Turp 2000b, 2001). In addition, I suggest that the narration of 'body storylines' (Turp 1999b, 2001, ch. 10, ch. 11) in the therapeutic setting and the exploration of their personal meanings offers a valuable opportunity for, in Winnicott's terms, 'joining up' physical and mental dimensions of experience and hence for enhancing 'psychosomatic indwelling', identified by Winnicott as a essential to healthy functioning (Winnicott 1949, 1966, 1970).

Infant observation, undertaken in an 'ordinary family' setting, lends itself readily to the exploration of what is involved in 'health' and 'normal development'. Understandings emerge which would not become available if the psychoanalytic focus were to be limited to situations involving obvious pathology. One such understanding concerns the implications for an infant/toddler's sense of self and for family dynamics of the normal, developmentally pre-programmed, achievement of physical mobility (Turp 1999c, 2001:120–128).

Another theme explored in the work is the healthy tendency towards self-caring behaviour. As noted earlier, the concept of health has been described as potentially

'disciplinary' (Foucault 1970, 1984), the basis for exhortations towards constant self-surveillance and self-criticism. I note that:

> Against this background, it becomes difficult to discuss the subject of care and self-care without appearing to subscribe to the view that we should constantly try harder to maintain our own and or children's mental and physical health, as if we were engaged in some kind of a 'project' (Turp 2003, p.19).

A perhaps unexpected advantage of a focus on 'health' and 'normality' is the emergence of complex and subtly shaded account of what is actually involved. This picture tends to militate against the danger of becoming subject to the tyranny of 'the myth of perfect health' (Turp 2001:14). Taken overall, the picture that emerges confirms the Kleinian account of the mixed nature of ordinary human experience:

> A normal childhood is a very mixed bag, often not so much a matter of a continuous smooth ride as of a million minor recoveries (Turp 2001:125).

The complex nature of self-care and is likewise affirmed. Reflecting on infant observation, case study material and discussions of clinical vignettes with other practitioners, I caution against the idealisation of self-care, arguing that only a fine line divides self-harming behaviour from 'normal' behaviour. The border territory is identified as the domain of the 'casha'. I suggest that 'cashas' provide a safe outlet for self-destructive impulses and that the need for such outlets is widely, if unconsciously, recognised in the sense that all societies, as far as I am aware, tolerate a certain range of health-impairing, risk-taking and self-injurious behaviours (Turp 2003:30-31).

The paradoxical nature of self-care is also highlighted, with examples being given of tensions between best physical self-care and best emotional self-care and of situations where too great an emphasis on physical self-care proves to be prejudicial to overall functioning (Turp 2003:34).

I continue to argue for explicit attention to be paid to self-care and other health and recovery-oriented behaviour in order to extend psychoanalytic thinking and to contribute to a balanced account. With regard to self-care, the relevant observation material is set in relation to the Kleinian discussion of internalisation of a good object. The maternal function of ordering of events for the infant through the provision of a sequencing commentary on the infant's day is identified and referred to as the provision of a 'narrative skin' (Turp 2003, 2004 forthcoming).

ii Elaboration and innovative application of the concept of 'the psyche indwelling in the soma'

Winnicott's writing on 'the psyche indwelling in soma' is revisited and brought to bear in new contexts. His description of a key maternal task of 'joining up' of psychological and physiological dimensions of experience (Winnicott 1970) is highlighted and linked to his later work on the positive function of psychosomatic disturbance. These are aspects of Winnicott's work not previously been selected for further development.

According to Winnicott's account, a subjective experience of mind-body unity – the 'unity psyche-soma' – is a crucial aspect of the experience of health and of healthy functioning. The 'duality psyche-soma' - a sense of the body that *belongs to* rather than *is* the individual is associated by Winnicott with defensive psychosomatic splitting and psychosomatic disturbance. According to Winnicott, psychosomatic symptoms are recovery-oriented insofar as they express an unconscious refusal to allow the damage to the integrity of the psyche-soma to pass unnoticed and communicate an unconscious demand, not least by means of their nuisance value, for the underlying state of mind/body dissociation to be addressed (Winnicott 1966).

This perspective is compared and contrasted it with other psychoanalytic accounts of psychosomatic disturbance rooted in a dualistic perspective (Turp 1999b, 2001:71). Building on Winnicott's account of the function of psychosomatic symptoms, other examples of unconscious endeavours to develop safeguard or repair damage to indwelling or 'psychosomatic health' are identified and discussed. Set in relation to childhood experience, this perspective highlights the psychological significance of achievements such as learning to walk, run, jump and swim. Set in relation to adult experience, it offers a new way of thinking psychoanalytically about engagement with touch and movement activities, for example sport, physical exercise and massage (Turp 1997, 1999b, 2000a, 2000b, 2001). These matters, while central to complementary medicine approaches, have previously been little addressed within the field of psychoanalysis.

The phenomenon of 'the psyche indwelling in the soma' is extended into the idea of a 'body storyline' (Turp 1999b, 2001 ch. 12). A body storyline is characterised as a history of touch and movement physically inscribed on to and into the individual, which in turn shapes the individual's 'stance' in the world and responses evoked in interpersonal encounters, including analytic encounters. Infant observation and adult case study material is introduced to support the suggestion that this stance - while continuing to reflect social status and cultural influences - is strongly coloured by

individual experience with significant others. A specific suggestion to emerge from these reflections is that an individual's stance in the consulting room, sometimes accompanied by descriptions of troubling physical symptoms, may be understood as an unconscious communication of damage to the integrity of the psyche-soma and an unconscious request for assistance with the task of joining, or re-joining, mental and visceral dimensions of experience. This contention is supported by descriptions of clinical work with clients who have used physical activities, together with reflection in psychotherapy on personal meanings of those activities, in the service of emotional recovery.

In a 'body storylines' approach, elements of the client's narrative that refer specifically to experiences of touch, movement or other aspects of physical self-experience are privileged, being selected for interpretation and elaboration whenever a suitable occasion arises. Client engagement with physical activities outside the consulting room is seen as meaningful and potentially beneficial in relation to the task of addressing damage to the unity of the psyche-soma (Turp 1997, 2000b). Accordingly, the client is encouraged to reflect on associations and emotions arising in relation to physical activity. I suggest that this modification of technique is particularly useful when psychosomatic symptoms are a major feature of the clinical picture (Turp 1999b, 2001: 191-192).

The act of narrating the storyline – the 'storying of experience' (Turp 2001:180) is characterised as transformational rather than a simple matter of recollection. The example of the 'coffee expert', who tasted coffees from all over the world, developed a vocabulary for the characteristics of different coffees and was then able to taste differences which had not previously existed for him, is invoked in support of this line of thinking.

In Turp 1999a and Turp 2003, these ideas are brought in relation to the issue of self-harm. Self-harming behaviour is seen as an aspect of the individual's body storyline. Examples are given of clinical work with clients who recall in psychotherapy situations where they have cut off from bodily experience in the face of traumatic events and overwhelming feelings. Later in life, this well-practiced defence of dissociation and accompanying feelings of numbness and unreality are re-evoked by any difficult situation, leading to a sense of desperation which is in turn relieved by self-inflicted pain.

The provision of a therapeutic environment in which a verbal narrative corresponding to the physically expressed storyline can be created brings the possibility of recovery.

This work falls broadly within the framework of the normal psychoanalytic endeavour of negotiating between concrete and symbolic functioning and bringing thinking into relation to feeling. Against this background, I argue for the value of paying detailed attention to body-centred narratives and somatic aspects of countertransference experience.

iii Innovative application of psychoanalytic infant observation

Psychoanalytic infant observation, centred on the experience of growing up in an 'ordinary' family, supports the holding-in-mind of normal development and testifies to the resilience, as well as the vulnerability, of infants and children. Weekly observations, usually lasting one hour and taking place in the family home, offer the observer a unique experience of the powerful dramas of infant life.

In the submitted work, extracts from and reflections on infant observation studies are used in a number of new ways. An important theme, once again, is the establishment (or non-establishment) of 'the psyche indwelling in the soma' and the role of the early environment in this development. Infant observation, both the experience itself and the theory that has evolved on the basis of the experience, highlights the emotionally meaningful nature of physical self-expression and offers an apt context for the elaboration of this theme. Winnicott's writing was grounded in observations of mothers and babies in a clinic situation. Psychoanalytic infant observation confirms his findings in some respects but in others present a different, less idealised, picture of mother-infant relationships.

One of the observations cited ('Emma' in Turp 2001) offers an illustration of a 'body storyline' becoming physically inscribed into the infant's way of being and stance in the world. In response to her mother's depressed mood and associated deficits in maternal holding and handling, Emma's acquires a slack, drooping posture, her facial expression and body movements become unanimated and she suffers from a variety of minor ailments. I suggest that the health crisis that comes after eleven months, one that demands hospitalisation of Emma and her mother, is at least partly psychosomatic in origin. This observation also demonstrates how changes in the child's physical competences interact with the mother's state of mind. In this case, both the onset of mobility and the health crisis combine with the beginnings of the mother's emergence from a depressed mood state and these developments usher in a period of recovery for 'Emma'.

In Turp 2003, infant observation is used to explore the evolution of a capacity for self-care. Observations of 'Esther' suggest that the internalisation of a good object and the

establishment of a robust sense of the psychosomatic indwelling are two important factors involved in the development of such a capacity. There are immediate applications here for clinical work with clients who engage in self-harming behaviour, with attention being drawn to the need to attend to the absence of self-caring tendencies as well as to the presence of self-harming tendencies.

Understandings emerging from my involvement in psychoanalytic infant observation are complementary to those described in work of ed. Miller, Rustin, Rustin and Shuttleworth (1989), S. Briggs (1997), Reid (1997) and Asha Phillips (1999). Infant observation continues to be a site of considerable creative and innovative work, as is evidenced in contributions to the journal 'Infant Observation' and in a recently published collection of papers (ed. A. Briggs 2002), testifying to a growing range of applications in a wide variety of settings.

Developments have for the most part revolved around child and, to a lesser extent, adolescent psychotherapy. In my work, understandings emerging from infant observation - from personal participation in the process and from relevant developments in post-Kleinian theory - are brought into relation to once or twice-weekly psychoanalytic psychotherapy with adult clients. This is a conjunction with a long history, dating back to Bick's own paper 'Further considerations on the function of skin in early object relations' which bears the subtitle 'Findings from infant observation integrated into child and adult analysis' (Bick 1986). Nevertheless, it is a conjunction which has not been the norm and the submitted work is unusual in offering an extensive account of infant observation understandings brought into the service of psychoanalytic psychotherapy with adult clients.

iv. Development and application of the concept of 'Narrative Skin'

The theoretical perspective developed by Bick (1968) and her colleagues emphasises the fragile sense of cohesion which is part of the normal experience of infancy and which continues to be a significant aspect of adult functioning, particularly where containment has been inadequate. In my work, this understanding is brought into relation to the specific issue of self-harming behaviour. Reference is made to the role of the skin, both literal and metaphorical, in holding the individual together, safeguarding coherence and at the same time permitting the interpenetration of internal and external worlds of experience. I suggest that the concept of a toughened psychic skin - Bick's 'second skin' - offers a useful way of thinking self-harm, particularly self-harm involving self-cutting or self-hitting, and about the 'tough', impervious and sometimes confrontational behaviour of some clients who harm themselves. I suggest a further

potential link between 'self-harm by omission', characterised as 'behaviour that leads to significant injury or damage to health through inaction rather than action' (Turp 2003:60), and Briggs' concept of 'porous skin' (1997, 1998), which describes the situation where the infant has effectively given up on the task of maintaining a resilient boundary between self and others (Turp 2003:60-61).

The psychic skin function of 'narrative skin' is identified on the basis of observations of parental narrations of sequences of events. Typically, the narrative involves an account, spoken aloud to the infant, of what happened earlier in the day, what he or she has been doing, what is happening now and what is planned for later. In normal circumstances, sequencing statements of this nature appear to be a consistent feature of parent communications to their infants, often being provided at key moments, for example when the infant wakes up from a sleep and functioning as a kind of 'news update'. I suggest that this ordering and sequencing function ordinarily becomes a part of the internal repertoire of the older child and adult and that self-harming behaviour may indicate, among other things, damage or deficits in this area of functioning. The sequencing element is held to be important and distinctive, so that a 'sonorous skin' (Sorensen 2000) is not quite the same thing as a narrative skin (although a narrative skin may also be sonorous) (Turp 2003: 62-66, 2004 forthcoming).

In case study material contained in Turp 2003, revolving around work with clients who harm themselves, examples are given of states of internal chaos, experienced in the countertransference and emerging externally in the form of missed deadlines and missed sessions. This state of affairs leads me to suggest that these clients lack a well-functioning narrative skin, which is to say that they lack the capacity to sequence thoughts, actions, emotions or memories in an orderly way. This situation is consistent with states of mind experienced by the client as 'crazy' and with associated behaviour such as self-cutting which conveys a sense of extreme agitation and desperation.

The provision by the psychoanalytic practitioner of a narrative skin, presumed to be an area of experiencing where the original maternal provision was inadequate, is shown to be helpful. In one case, the client internalises this provision to the extent that she is able to plan a holiday, the first ever with her partner of seven years, to investigate college courses and to begin to make career plans (Turp 2003, ch.6). In another case, the client internalises the provision sufficiently to be able to return to a long-lost source of emotional containment, that of reading novels. Reading fiction becomes a supplementary source of soothing and sequencing, leading to an improvement, albeit a limited improvement, in her functioning and overall state of mind (Turp 2003, ch 7).

v Elaboration and innovative application of the concept of somatic countertransference

I argue that an implication of a holistic perspective is that body experiences can affect mental functioning and that mental experiences can likewise affect body functioning (Turp 2000a, 2000b, 2000c, 2001:132-133). If input via any channel can connect to the whole feeling, thinking, embodied person, then there is no logical contradiction involved in the idea that verbal psychotherapy can be an effective treatment for physical symptoms or that a physical action, such as a massage or a session at the gym, can relieve emotional anguish.

This situation brings into view a question with a long history, the question of whether it is helpful to include touch and movement experiences in psychoanalytic practice. Splits and disagreements, for example between Freud and Reich and Freud and Ferenczi, are part of that history and much has been written on the issue, including an important contribution from Casement (1982). The relevant history is discussed in Turp 2000a, 2001, ch 5 and 2001:138). Reference is made to ethical issues and to the erotic associations of touching between adults in our culture. The main discussion, however, centres on formalised physical contact of the kind employed in body psychotherapy.

The conclusion drawn is that concrete experiences of touch and movement are indeed important to psychological well-being but belong, as far as psychoanalytic practice is concerned, outside the consulting room (Turp 1999b, 2001:66-67). I argue that body psychotherapy activities, such as massaging the client, necessarily interfere with the transference-countertransference dynamic, since the therapist is obliged to take up an authoritative, specialist and 'expert' position and hence cannot be fully available for the client's 'use', in the sense of client's unconscious positioning of the therapist in his or her inner world. The situation is perhaps different in work with young children (of which I have no direct experience), where touch experiences are not contrived but form a part of normal interaction, such as playing, between the child client and the adult psychotherapist.

In relation to adult psychotherapy, I endeavour to develop and describe a style of practice which integrates a holistic perspective on the human subject with an object relations approach. Body psychotherapists argue that working with the whole embodied person is possible only if experiences of concrete touch form a part of the therapeutic approach, an assertion/assumption which is explicitly challenged (Turp 2000a, 2000c, 2001). Writing from within a psychoanalytic perspective, I refer to the importance of symbolic functioning and the development of symbolic equivalents of touch from

childhood onwards (Turp 2000a, 2001 ch. 7). Throughout the work, through the presentation of detailed clinical examples, I endeavour to convey a sense of psychoanalytic psychotherapy as a body-to-body matter involving many forms of physical and quasi-physical contact, including subtle postural mirroring and adjustment.

Somatic countertransference is a subject of increasing interest in contemporary psychoanalytic writing (Orbach 1995, Field 1989, Ogden 1997). This development represents a departure from traditional psychoanalytic practice, which has been characterised by the privileging the narration and exploration of 'mental' rather than 'physical' experiences. Nathan Field (1989) describes a stance of 'Listening with the body', a clinical approach in which particular attention is paid to somatic aspects of countertransference phenomena, seen as highly significant and involving the unconscious communication of experiences for which there are, as yet, no words. Ogden (1997) describes images and events drifting to mind in the consulting room which at first seem incomprehensible but are eventually understood as emanating from unconscious client communications.

My own contribution in this area includes descriptions of and reflections on my own 'use of body' in the sense referred to above. These include periods of dizziness, attacks of 'pins and needles', finding myself adopting an unnaturally stiff and upright position, feelings of breathlessness and headaches, all of which disappear within a short time of the client departing from the consulting room. Working with unconscious communication in the transference and countertransference is seen as a process which depends on and in turn builds emotional contact with the client. I suggest, again through the presentation of clinical work, that attending closely to somatic aspects of countertransference phenomena serves to heighten awareness of emotions and dynamics active beneath the surface of client narratives.

The suggestion that meaningful touch and movement experiences help conserve somatic awareness and enhance aspects of functioning dependent on 'the psyche indwelling in the soma' is seen as relevant to practitioners as well as to clients. I suggest that the therapist's sensitivity to unconscious somatic communication is linked to his or her body awareness, informed in turn by his or her engagement with and associations to physical activity (Turp 2001:186-187).

I have referred to psychoanalytic psychotherapy as an appropriate site for reflection on and elaboration of personal meanings of physical activities, including sport and exercise activities. Receptivity to and, where appropriate, interpretation of unconscious somatic communications is seen as complementary to the exploration of layers of

meaning present in a client's narratives of engagement in sport, leisure exercise or other touch and movement activities. Taken together, these developments constitute a subtle shift in practice, one which helps to ensure that somatic events and communications are seriously taken into account in psychoanalytic practice.

3.3 METHODOLOGY

The submitted work is grounded in psychoanalytic practice extending over a period of ten years and in three psychoanalytic infant observation studies undertaken between 1995 and 2001. Case study methodology and psychoanalytic infant observation are identified as research methods appropriate to the field of psychoanalysis, where the aim is a detailed understanding of the inner world of the individual and where clinical responsibilities and respect for the autonomy of the individual militate against the imposition of experimental conditions (Turp 2003:41-42).

Case study methodology is the traditional tool of psychoanalytic research. It has affinities with paradigmatic and narrative approaches (ed. S. Toukmanian and D. Rennie 1992) and formal approaches to textual analysis, for example discourse analysis (Parker 1992, Taylor and Loewenthal 2001). In making the case for my reliance on this methodology, I comment that:

> While each story is individual and particular, pattern and meaning emerge over time as certain themes are repeated, both within the narrative of an individual client and between the narratives of a number of clients (Turp 1999b:303).

Clinical material is used in different ways in the work, in the form of vignettes, case studies compiled from experiences with more than one client and minimally altered case studies published with the permission of the client involved. Practical and ethical issues raised by these procedures are discussed in Turp 2003:74-77.

Case study research, while widely accepted within psychoanalysis, is viewed with scepticism in neighbouring fields, particularly in the field of medicine, including psychiatry, and psychology. In these fields, case study material has up until recently been seen as merely anecdotal and has not qualified as 'evidence'. The significance of the postmodern critique of distinctions made between 'subjective' and 'objective' knowledge is discussed (Turp 2001, ch.4). Growing awareness of the limitations of the scientific method is associated with a measure of change. A number of texts focussed specifically on case study research have appeared in the last decade, including Yin 1993 and McLeod 2002. An attitudinal shift is perhaps reflected in the invitation extended to me by the National Institute for Clinical Excellence (via the British Association for Counselling and Psychotherapy, which is a NICE stakeholder) to submit

my work on self-harm as 'evidence' in relation to a review of clinical services for this client group.

Turp 2001 discusses the relationship between psychoanalytic understandings and sociological research into health and health inequalities. I argue that different approaches are complementary and the source of different kinds of understandings and make a case is for the particular value of psychoanalytic research:

> I will say, though, that a full understanding of inequalities in health depends not only on identifying the key external factors but also on understanding how individuals interpret their experience of an environment. Why does one person remain healthy in a disadvantaged situation while another falls ill? How does a low income translate into poor health at the level of the individual? It is in considering these questions from the point of view of the experiencing subject engaged in bringing meaning to his or her experiences that psychoanalytic thinking can make a valuable contribution. The point is not to arrive at general laws of connection between circumstances and individual health, *but rather to understand what it is like for an individual child or adult to sustain, to lose, or to recover a state of health* (Turp 2001:11).

Because it has the same structured form and 'rules of engagement' and because it also generates new ideas and insights, psychoanalytic infant observation has been described as Reid (1997) as a second core psychoanalytic methodology to stand alongside the clinical case study method. It is a naturalistic and longitudinal research method involving the observer in a form of 'participant observation' not unlike that involved in ethnocentric sociological and anthropological research. This kind of observation began its life as a 'special and valuable form of learning' (Turp 2001:77), one with an unequalled potential for sensitising the observer to the play of unconscious dynamics, both within the internal world of the infant and between the infant and his or her primary carers.

Its use as a tool of research is a more recent phenomenon, discussed in S. Briggs 1997 and Reid 1997 and referred to in Turp 2001. Michael Rustin (1997, 2002) provides a detailed theoretical discussion of the kinds of data and experience that infant observation can provide, describing parallels between infant observation methodology and complexity theory. He identifies in the paradigm of complexity theory the possibility of transcending the 'unwelcome dichotomy between causal reductionism on the one hand, and a merely interpretative investigation of narratives on the other' (2002:263).

Material from other sources is used to complement and corroborate ideas generated by case study and infant observation material. The contribution of developmental psychologists is acknowledged and differences between psychoanalytic infant observation and laboratory based observation are discussed (Turp 2001:81-82). A small empirical study undertaken by the author is described, in which clinical vignettes are presented to counsellors and psychotherapists and discussed with the aim of differentiating between examples of 'cashas' and examples of self-harm. This study, described in Turp 2002 and included as chapter 2 in Turp 2003, played an important role in the development of the 'continuum model' of self-harm.

Larger scale psychoanalytic studies are used as a secondary resource where available and appropriate. Such studies offer an element of methodological triangulation (Denzin 1970), adding to the validity of the arguments advanced; for example Hopkins (1990) description of postural changes in touch-deprived infants lends support to the idea of a 'body storyline' physically inscribed into and on to the individual from the earliest days of life.

Findings from other fields of study, for example health psychology, sociology, physiology and neuroscience are also referred to. In one example, psychology research on motivation within the field of exercise psychology is cross-referenced with client accounts of the individual experience of exercise (Turp 1997). In another, research into the effects of enhanced touch experiences on the physiological development of premature infants is used to inform the interpretation of material emerging from the observation of full term infants (T. Field 1995 cited in Turp 1999c, 2001:106-109). A social survey into self-harming behaviour conducted from a feminist perspective and involving interviews with 76 women (Arnold 1995 cited in Turp 2003) provides a backdrop to the work on self-harming behaviour. Other fields of study identified as relevant include popular culture (Turp 1997, 1998, 2000b), feminist studies (Turp 1999a, 2003), mammalian behaviour studies (Turp 1999c), body psychotherapy (1999b, 2000a, 2000c) and the physiology of touch, movement and proprioceptive function (Turp 2000a).

3.3 COHERENCE OF SUBMITTED PUBLICATIONS

Each of the submitted publications revolves around an aspect of the interplay of physical and psychological dimensions of experience. An object relations approach underpins the whole of the work.

The themes developed interconnect and in some respects overlap, lending the work an essential coherence. A further source of coherence is the frequent reference to two

theoretical perspectives, Winnicott's concept of indwelling and Bick's concept of psychic skin and the identification of points of contact and overlap between Winnicottian and post-Kleinian perspectives.

Phenomenological and post-modern sensibilities are an enduring undercurrent, present from the start and occupying a more significant position in later work. Relevant themes are tendencies within psychoanalysis which oppose the pressure towards theoretical closure and affinities between these tendencies and aspects of post-modern thought, in particular discussions of the status of 'truth' and 'reality' on the one hand and 'social construction' and 'narrative' on the other (Turp 2001:36-38).

The consistency of the methodologies employed is an additional source of coherence. Each publication includes clinical examples, whether in the form of vignettes or longer case studies and many of the publications include extracts from infant observations studies. Reference to qualitative and quantitative research undertaken in neighbouring fields is also a recurrent feature of the discussion and evaluation of original material.

3.5 RECOGNITION AND IMPACT OF THE WORK

Publications have resulted in acceptance of conference papers, invitations to speak and the development of workshops on the subjects of psychosomatic distress and self-harming behaviour. I have received twenty-five written communications (not appended for reasons of confidentiality), some from practitioners, some from individuals concerned about their own experience and behaviour and some from individuals with professional responsibility for services, for example a Nurse Manager in an NHS Accident and Emergency department. In June 2003, the Counselling and Psychotherapy Journal (circulation of 21,500) featured my work in the editorial and in a report titled 'Self-Harmers – a group apart?' A copy of this report is included in Appendix 3.

Speaking engagements are listed below in reverse chronological order:

(2004 forthcoming) Invited speaker, *Audiences with Authors*, London Centre for Psychotherapy.

(2003 forthcoming) 'Skin boundaries, skin defences.' Invited speaker, opening lecture in series *Defences*, organised by Confer.

(2003 forthcoming) Guest speaker at Harlow Well Women Centre AGM.

(2003) 'The doctor's health: recognising and managing the impact of unconscious somatic communication.' Lecture in series *Working with Psychosomatic and Unexplained Symptoms in General Practice*, Royal College of General Practitioners.

(2003) 'The depressed mother: an infant observation study.' Invited speaker in lecture series *Resolving Depression: New Theory and Practice*, organised by Confer.

(2003) 'Physical communications and talking cures.' Paper given at the *Annual Conference* of the Institute for Psychotherapy and Social Studies.

(2002) 'The many faces of self-harm.' Paper given at *Annual British Association of Counselling and Psychotherapy Research Conference.*

(2002) 'Psychosomatic Issues: mapping the terrain'. Opening lecture in series *Working with Psychosomatic Symptoms* organised by Confer.

(2001) 'Self-harm and self-care: a phenomenological approach.' Paper given at the *Cutting Edge Conference* organised by the University of Hertfordshire.

(1999) 'From self-harm to self-care: How can we help?' Talk given at *Westminster Pastoral Foundation Staff Training Day.*

(1998) 'Self-harm: an example of a multi-professional issue.' Paper given at *Multiprofessional Issues in Social Care Conference* organised by the University of Hertfordshire.

In response to expressions of interest, I have developed to two day-long training workshops, entitled 'The Physical Expression of Psychological Distress' and 'Self-Harm, Self-Care and the Way Between'. The programmes for these days are included in Appendices A and B. To date, the workshops have been conducted for Hitchin Counselling Service (2002), Stevenage Women's Resource Centre (2002), Wantage Counselling Service (2003) and Newbury Talk 21 Service for Young People (2003). Bookings have also been made by the Yorkshire Association for Psychoanalytic Psychotherapy (October 2003) and Enfield Counselling Service (February 2004).

An important aim of the work has been to extend the influence of psychoanalytic thinking and its range of applications. Evidence of progress in relation to this aim can be seen in the acceptance of conference papers by the University of Hertfordshire for a Multiprofessional Issues in Social Care conference and by the Royal College of General Practitioners for a lecture series on Working with Psychosomatic and Unexplained Symptoms in General Practice; also in an invitation to submit evidence to 'NICE' (National Institute for Clinical Excellence), in the participation in my training workshops of mental health practitioners and secondary school teachers and in an invitation to be guest speaker at the AGM of the Harlow Well Women Centre (October 2003). In addition, I have been invited to write a regular column for the publication

'Mental Health Today', a monthly magazine with a readership consisting primarily of mental health nurses, psychologists and service users.

In April 2002, I was invited to join the editorial team of the journal 'Psychodynamic Practice' (formerly 'Psychodynamic Counselling') and I now edit the 'Open Space' section of the journal. In April 2003, I was appointed Infant Observation Seminar Leader on the MSc in Psychodynamic Counselling with Children and Adolescents at Birkbeck College, University of London. In May 2003, I was invited to join the Editorial Board of the Journal 'Infant Observation'. In March 2003, I put forward a suggestion to develop an infant observation programme for counsellors working in general practice and in the voluntary sector. This suggestion has been taken up by the Tavistock NHS Trust and preliminary work on the project is currently in progress.

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APPENDIX 1

Workshop Programme: 'The Physical Expression of Psychological Distress'

THE PHYSICAL EXPRESSION OF PSYCHOLOGICAL DISTRESS

A day workshop led by Maggie Turp

10.00 - 10.15 INTRODUCTION

10.15 - 11.30
THE NATURE OF PSYCHOSOMATIC DISTURBANCE: PSYCHODYNAMIC AND NEUROSCIENCE PERSPECTIVES

Winnicott's account of 'the psyche indwelling in the soma'

Conversations between Richard Bowlby and Allan Schore (video)

11.30 - 11.45 COFFEE

11.45 - 1.00
HOW DOES THE EARLY ENVIRONMENT SUPPORT OR UNDERMINE A TENDENCY TOWARDS INTEGRATED BODY-MIND FUNCTIONING?

Readings from and reflections on infant observation studies

1.00 - 2.00 LUNCH

2.00 - 3.00
WORKING WITH SOMATIC ASPECTS OF TRANSFERENCE AND COUNTERTRANSFERENCE PHENOMENA

Discussion of the counsellor's use of somatic awareness as an aspect of working with countertransference phenomena, drawing on clinical examples

3.00 - 3.15 TEA

3.15 - 4.15
HOW DO PSYCHOSOMATIC ISSUES PLAY THEMSELVES OUT IN YOUR PRACTICE?

Workshop participants are invited to bring along their own examples for group discussion

maggieturp@aol.com

APPENDIX 2

Workshop programme: 'Self-harm, Self-Care and the Way Between'

SELF-HARM, SELF-CARE AND THE WAY BETWEEN

A day workshop led by Maggie Turp

10.00 - 10.15 INTRODUCTIONS

10.15 - 11.15

ABOUT SELF-HARM ... (SLIDES)

11.15 - 11.30 COFFEE

11.30 - 12.30

SELF-HARM AND 'CASHAS' (culturally accepted self-harming acts/activities)

Drawing on clinical and personal material, we will consider the questions:

Is self-directed violence the only kind of self-harm?

What do we think about behaviours such as smoking, chronic overworking and reckless driving?

How do our assumptions affect our work?

12.30 - 1.30 LUNCH

1.30 - 2.30

EARLY EXPERIENCE AND THE CAPACITY FOR SELF-CARE

Readings from and reflections on extracts from psychoanalytic infant observation studies

2.30 - 2.45 - TEA

2.45 - 3.45

CLINICAL WORK WITH INDIVIDUALS WHO HARM THEMSELVES

Participants are invited to bring examples from their own practice for discussion

3.45 - 4.15

QUESTIONS AND REFLECTIONS

maggieturp@aol.com

APPENDIX 3

'Self-Harmers: a group apart?'

Report in Counselling and Psychotherapy Journal, June 2003.

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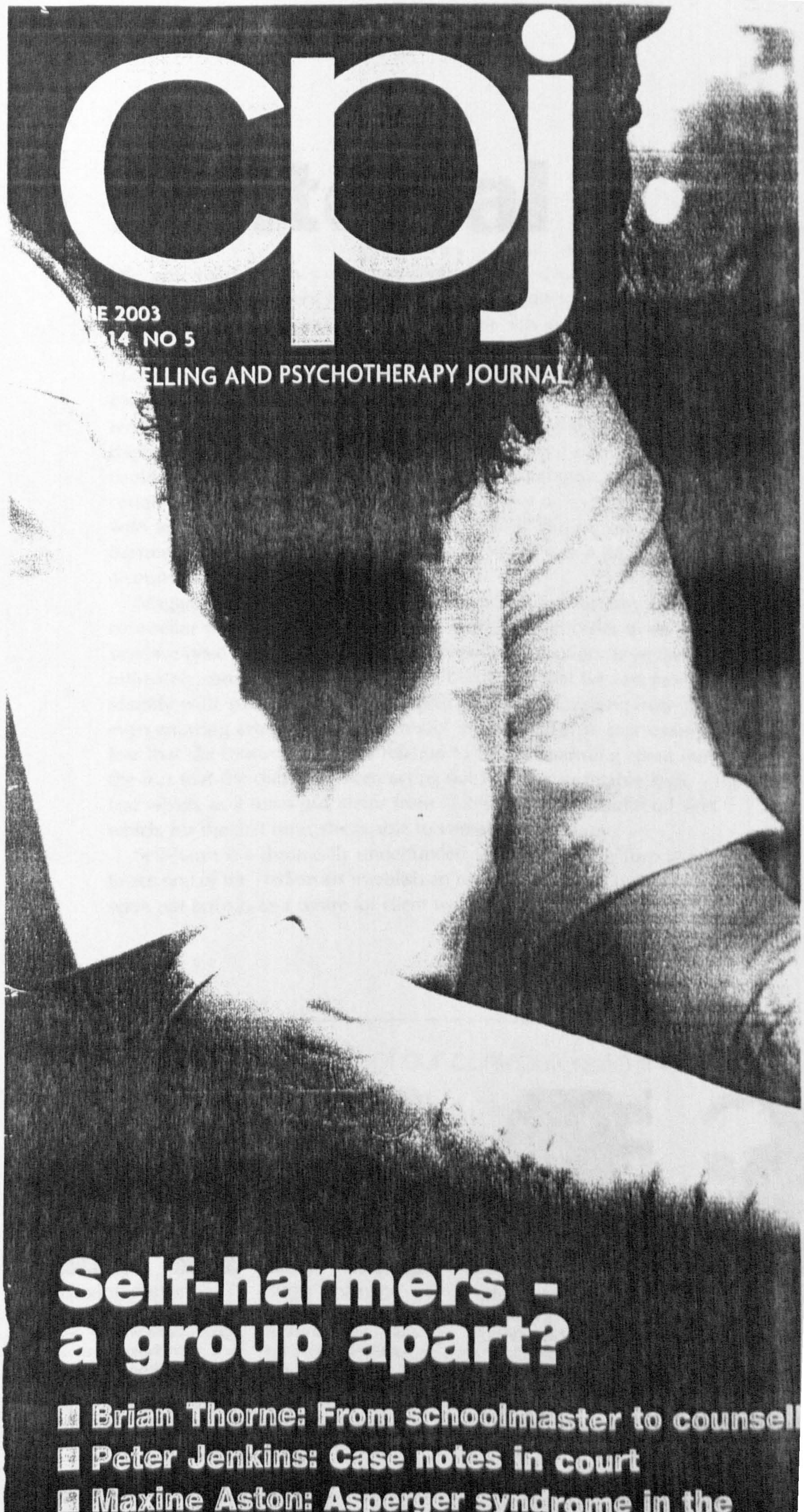

Self-harmers - a group apart?

- Brian Thorne: From schoolmaster to counsell
- Peter Jenkins: Case notes in court
- Maxine Aston: Asperger syndrome in the counselling room

Editorial

We carried a short news story last month on a new survey which revealed that one in 10 teenagers self-harm – mostly by cutting or poisoning – with girls being four times more likely to do so than boys. This month we have an article about working with self-harmers which I personally found very moving and which gave me a new understanding of this area. Like the counsellor in Maggie Turp's fictional case study (page six), I have always tended to view self-harmers with a mixture of fear and horror and seen them very much as a group apart, disturbed in some extreme way that I could not identify with. It seems that this is a commonly held view and certainly many counsellors I have spoken to have no experience of working with self-harm – one woman who works in a GP surgery told me that self-harming clients would be more likely to be referred to a psychiatrist than to a counsellor.

Maggie Turp makes a very powerful case to show that any effective counsellor can work with self-harming clients. But in order to do this, she says, we need to understand how self-harming behaviour is in fact intimately connected to other forms of behaviour that we can more easily identify with, such as heavy smoking or drinking, punishing over-work, even gnawing away at one's fingernails. In Maggie Turp's case example, the fear that the counsellor feels in relation to her self-harming client mirrors the fear that the client has been acting out with her vegetable knife – the fear which, as it turns out, stems from violent abuse in childhood, and which, for the first time, she is able to verbalise in therapy.

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This month: Five of our contributors to this issue of C

Maxine Aston

BSc Hon Psychology, C.C. Cert. Relate, works as a couple counsellor, specialising in couples and families affected by Asperger syndrome. She is the author of *Aspergers in Love* (2003) Jessica Kingsley and other books.

Brian Thorne

used to be a teacher of modern languages. He is now Emeritus Professor of Counselling at the University of East Anglia and Co-founder and Professional Fellow of the Norwich Centre

Peter Jenkins

is a lecturer in counselling at Manchester University and Editor of *Legal Issues in Counselling and Psychotherapy* (Sage, 2002) and other books

Andy Rogers

is a part-time counsel further education and part-time bookseller. H special interest in critic approaches to psych counselling and psychotherapy, and r professionalisation.

Self-harmers
a group apart?

MPHRY/PHOTOFUSION

People who self-mutilate are often seen as a group apart, their behaviour shocking and socially unacceptable. But, according to psychotherapist and supervisor Maggie Turp, self-harm is intimately connected to a whole range of culturally acceptable self-harming activities such as over-work or heavy smoking. Bringing 'normal behaviour' and self-harming behaviour closer together, she argues, can help practitioners to identify with their self-harming clients, as she explains to Claire Pointon

'A COUNSELLOR in supervision with me, "Janet", discusses a new client, "Sally". At her second session, Sally reveals that she has intentionally cut herself. In response to Janet's enquiry, she says that she has done the same thing before, but not for over a year. She describes how this time she felt compelled towards self-cutting and yet tried to resist the compulsion. Her eyes kept being drawn to the kitchen drawer. Eventually she took out a sharp vegetable knife that she knew was there. She replaced it, then took it out again. She "hid" it, went out and bought a pint of milk. But when she returned, she retrieved the knife and cut herself on the arm. (At this point, Janet describes feeling a "clenching feeling" in her stomach.)

Sally says that she had "kind of gained control over the situation", but had then allowed herself the self-injury. She tells Janet "I knew I was on the edge. It was the only way to be sure that I wouldn't start hitting the kids and screaming at them five minutes after they got in from school."

Janet keeps her outward response neutral and plays for time, saying that this is clearly a subject that will need careful consideration.

In supervision Janet wonders whether Sally is a suitable client for the kind of counselling she offers – psychodynamic counselling once weekly. She feels she might find it too difficult to work with Sally, that Sally is perhaps too "disturbed". I bring into the supervision session the Kleinian concept of projective identification (Klein, 1946)[1], reminding Janet that the feelings being unconsciously stirred up within her by the client are there to be thought about and are likely to emerge as meaningful in the longer term. Janet identifies her primary emotional responses as fear and begins to wonder whether Sally herself has felt very afraid in the past and, if so, what has been so frightening for her.

We note that Sally has made an early reference to difficulties in managing anger, speaking of a fear of

hitting and screaming at her children. As we talk further Janet brings into the conversation her current endeavour to give up smoking. Apparently this sometimes involves taking out a cigarette and replacing it several times, "hiding" the packet and distracting herself by going for a walk or to do some shopping. Janet is making progress, but still "gives in" to a cigarette from time to time, particularly when she is feeling angry or upset.

These two developments – reflecting on the potential meaning of her emotional response and recognising parallels with her own behaviour – are directly helpful to Janet and indirectly helpful to Sally. Janet now feels fairly confident about working with this client and hopeful about the possibility of establishing a good therapeutic alliance. In the next session she comments on the high priority Sally places on being a good parent. Janet reflects that cutting had felt like the only way for Sally to calm herself down and be the kind of mother she wanted to be. Sally is clearly moved by Janet's comments and becomes quite tearful.

Subsequently Sally seems more trusting of Janet. The counselling continues for another year. She is able to talk about being physically abused by her father, who tied her up and beat her. Janet helps her to name the terrible feelings of rage and humiliation. Sally uses the time well and makes a number of significant changes in her life' (Turp, 2003)[4].

Socially unacceptable

People who self-harm are often seen as a group apart, their behaviour shocking, perhaps even frightening and more than likely socially unacceptable. That which most readily springs to mind may be self-mutilation, cutting, hitting or scalding – actions with which, many of us probably believe, we cannot identify. But can we? According to psychotherapist and supervisor, Maggie Turp, who works in the field, self-harm is intimately connected to a whole area of culturally acceptable (self-harming) activities – CASHAs – in which we all engage. Among these she counts overworking, heavy smoking and even nail-biting. For her, self-harm manifests as part of a continuum of behaviour ranging from 'good enough self-care' through 'compromised self-care', to 'mild self-harm', 'moderate self-harm' and 'severe self-harm'. And understanding the subtle gradation is crucial for practitioners in clinical work.

'I think the most useful thing about debating what to include is that it brings normal behaviour and self-harming behaviour much closer together,' she says. 'It provides a basis for people to identify with the emotional states of their clients and find a compassionate understanding for them, thinking of them as not entirely unlike us even though they're enacting something at a higher level of desperation. We all know about not taking the best possible care of ourselves or behaving without proper forethought.'

Maggie Turp believes much of the literature on self-harm has historically sensationalised the field by focussing on the florid examples at the cost of more hidden behaviours such as self-neglect. This attitude, she argues, has contributed to the perceived gap in society between those who self-harm and those who don't, one she believes is a defence against the kind of difficult feelings that get stirred up in us about self-harm. Equally unhelpful, she argues, have been theories based on the idea that self-harm is essentially attention-seeking. In her view this not only trivialises the person's

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experience, but also misses the main point. 'In most cases self-harm is not done for the response it evokes in others. It is done because it makes the person feel better. For each person, harming themselves has a function and that function is in relation to unresolved traumas and losses.' Contrary to popular belief, she argues, these are sometimes, but not necessarily, about sexual abuse.

How we think about what self-harm means to a person will depend on what we believe about how we evolve a capacity for self-care. From an object relations perspective, Maggie Turp, argues that this is mainly down to parenting in the first two years of life – and the availability or unavailability of a good internal object. Babies, she points out, are born totally dependent; they do not know how to self-soothe and the kind of care they receive at this point forms the basis of their own care of themselves later in life.

'Those who internalise a good internal object at this stage will be much better protected against what comes later, whatever it is,' she says. 'Those who don't won't have a sense of a benign internal world that includes the belief that they are worth taking care of and they will have great difficulty not acting on their destructive or self-destructive tendencies when they well up. If you haven't had the experience of being soothed at a young age, you might find yourself resorting to quite desperate measures to calm yourself down as an adult.'

So how can counselling and psychotherapy begin to address these

person feel better;

early deficits? For Maggie Turp the counsellor or therapist's work is 'to provide a place where what has previously only been able to be shown can start to be told, narrated in words.' This is a process she sees as being about providing the containment that was probably missing at some stage in

a person's life, listening to them in a thoughtful, calm and respectful way, processing and feeding back what they say, whilst allowing the feelings that are stirred up in oneself in response to be there, and being willing to look at these feelings. It involves thinking with the client about what has got them to this point and trying to understand what their behaviour is a symptom of. And it calls on the practitioner to be creative about

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options other than self-harm; looking at alternative ways in which they may have coped on occasion and helping them to find new strategies. By respectfully naming a client's feelings and opening a space to look at other behaviours, she believes the practitioner can help to lessen the client's sense of shame.

These aspects of the work have a cognitive behavioural flavour which Maggie Turp sees as useful early on in the process to 'give a client a handle on their symptoms', before moving on to the deeper psychotherapy in which the meaning of the behaviour will be explored. She believes short-term work of even 12 sessions can be useful for a young person or for someone who has not been self-harming for a long period of time. However, where the roots of the difficulty are early in life and the person's behaviour has become entrenched, it is more likely that they will need therapy lasting a minimum of six months to a year.

Countertransference

Most important in this field, Maggie Turp believes, is a practitioner's capacity to contact and work with his/her own countertransference – acknowledging the feelings evoked in him/her, being able to contain them and think about them without moving in either to rescue the client – perhaps by idealising them – or to retaliate – as in trivialising their behaviour. In her experience, counsellors and therapists working with this client group often feel high levels of anxiety.

I think what makes people feel wound up by this work and worried that what they do won't be enough is really to do with countertransference,' she says. 'Because the behaviour is shocking it stirs up very difficult feelings in the practitioner and then the practitioner feels that they've got to stop the person doing whatever it is.'

The danger is that, if they don't look at what is going on for them, they may find their anxiety pushes them into 'doing rather than containing'. In her view the practice of introducing a 'No Harm' contract as a condition of the work is one such example. For the therapist, she argues, this may offer a sense of containment for their own anxiety, but for the client, the danger is that if they do self-harm, they are likely to feel rejected, possibly even re-abused, when the contract is terminated.

Different approaches

In Maggie Turp's view this is work which any effective counsellor can do. She believes the basic process with self-harm is much the same as other counselling – and that any approach which uses psychodynamic insights linking the past and the present, as well as an understanding of the countertransference, can be effective. For her, many person-centred counsellors do just this work of careful listening, processing and feeding back. When it comes to managing what a practitioner experiences as challenging countertransference, she advocates the usual supports – good supervision, training and self-care.

To empower more counsellors to feel able to work with self-harm, Maggie Turp runs workshops, most at small counselling organisations or women's resource centres. These are usually one-day events which involve an exploration into the world of self-harm – hearing quotes from the clients about themselves, looking at case studies with

a view to understanding aspects of self-harm, CASHAs and stereotyping, considering extracts of infant observations to get a sense of how self-care does or does not get internalised – and having an experience of live supervision.

'People who are good practitioners who had thought they couldn't work in this field often go away thinking: 'Yes I'm already, in fact, doing what needs to be

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done. I don't have to come up with the magic bullet,' she says.

Maggie Turp's own long-term hopes for the field of self-harm are about raising its profile in the world of counselling and psychotherapy. She would like to see one of the NHS trusts establish an early intervention unit which could serve as a centre for client work, as well as research and learning. And she would also like to further preventative work at the level of infant mental health, offering support for parents juggling their own emotional needs with those of their children.

'Self-harm is an area that's been sorely neglected over the years, where services are poor,' she says. 'People come to me with such awful experiences as service users that I feel personally motivated to try and make a difference. This is the most underfunded group in our work and I feel moved by the injustice of it.' ■

Book offer: *Hidden Self Harm* by Maggie Turp is available from Jessica Kingsley Publishers at the discounted price of £15, postage free (full price: £18.95 plus £2.75 p&p). If you would like to order a discounted copy, phone 020 7833 2307 or fax 020 7837 2917, quoting 'BACP Special'.

References:

1. Klein, M. (1946) *Notes on Some Schizoid Mechanisms in Envy and Gratitude and Other Works* 1946-1963, London, Hogarth, 1987 in Turp, M. (2003) *Hidden Self Harm*, London, Jessica Kingsley.

2. Turp, M. (2003) *Hidden Self Harm*, London, Jessica Kingsley.